CATHOLIC INDEPENDENT SCHOOLS OF VANCOUVER ARCHDIOCESE

4885 Saint John Paul II Way, Vancouver, BC V5Z 0G3

CONFIDENTIAL

MATERNITY LEAVE MEDICAL REPORT

Patient Authorization:

Name (please print): _____ Date of Birth: _____
DD – MMM- YYYY

Address: _____

City, Province: _____ Postal Code: _____

Patient Signature: _____ Date: _____

Attending Physician Statement:

Date of Birth of the Child Day: _____ Month: _____ Year: _____

Complicating factors that impact the present health of the mother:

Complicating Conditions	*Severity of Condition*

Top-up/Recovery Period: Minimum of 6 weeks up to the maximum of 15 weeks.

Recovery period is needed to determine how many weeks of Top-Up the employee will be paid. The above mentioned patient is eligible for _____ weeks of top-up benefits
Between 6 – 15 wks only

Physician Name and Address:

_____ **Specialty:** _____

_____ **Signature:** _____

_____ **Date Signed:** _____

NOTE: Please DO NOT SUBMIT this form to the Benefits Office.

****To be submitted to the school not the Benefits Office. ****

V12-2016