

Return this form to:

Disability Certificate (OCF-3)

Use this form for accidents that occur on or after November 1, 1996.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

For this applicant, this is Disability Certificate number _____ from this health professional/facility

Use this form for accidents that occur on or after November 1, 1996. If your insurance company asks you to complete this form, fill out Parts 1 to 3 and give the form to your **health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist)**. After your health practitioner has explained your accident-related injury to you, sign Part 4. Your health practitioner will complete the rest of the form, based on his/her most recent assessment, and return it to the insurance company. Your health practitioner must forward the form to the insurance company within **21** days of your company sending this form to you or within 14 days of your insurance company notifying you that they intend to discontinue your benefits. **Only an authorized health practitioner can complete this form. The health practitioner's opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete. Please print clearly and provide all information requested. This form may not be materially altered.**

Confidentiality: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Part 1 Applicant Information To be completed by the applicant	Date Of Birth (YYYYMMDD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number	Extension
	Last Name			
	First Name		Middle Name	
	Address			
	City	Province	Postal Code	

Part 2 Insurance Company Information To be completed by the applicant	Name of Insurance Company		City or Town of Branch Office (if applicable)	
	Name of Insurance Company Representative:			
	Adjuster Telephone		Adjuster Fax	
	Name of policy holder same as: <input type="checkbox"/> Applicant OR	Policy Holder Last Name	Policy Holder First Name	

Part 3 Accident Description To be completed by the applicant	Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident.
	<input type="checkbox"/> additional sheets attached

Part 4 Applicant Signature	I authorize my treating health professional to collect, use and disclose to my insurer, any information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing health conditions that may be barriers to my recovery as a result of the automobile accident, for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid for one year from the date this form is signed.		
	I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties.		
	I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.		
	Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)

To the Health Practitioner:

Please complete the following information based on your most recent examination of the applicant named in Part 1 and return the form to the insurance company listed in Part 2. **Please print clearly.**

Part 5 Injury and Sequelae Information This part and the rest of this form must be completed by your Health Practitioner	Provide a description (list most significant first) and associated ICD-10-CA ⁺ code for any injuries and sequelae that are the direct result of the automobile accident.	
	Description	Code
Note ⁺ : Refer to the User manual at www.autoinsurancereforms.on.ca for ICD-10-CA coding information.		

Part 6 Relevant Dates	Date symptoms first appeared: (YYYYMMDD)	Date of most recent examination: (YYYYMMDD)
	Date of first post-accident examination: (YYYYMMDD)	(a) Applicant was seen by me prior to the accident. Yes <input type="checkbox"/> No <input type="checkbox"/> (b) If answer to (a) is yes, enter date on which applicant was first seen: _____

Part 7 Disability Tests and Information				
a) Based on your current knowledge and information provided by the applicant, please provide a response to each Benefit/Applicant Category				
Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task/Activity Limitations	Anticipated Duration
Income Replacement Benefits Employed: working at the time of the accident	Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
	Can the applicant return to work on modified hours and/or duties? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Unemployed: but worked 26 weeks during the 52 weeks before the accident	Is the applicant substantially unable to perform the essential tasks of the employment held for most of the time during the 52 weeks before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Future employment: had accepted a job offer to start work within one year of the accident	Is the applicant substantially unable to perform the essential tasks of the employment he/she would have begun? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task/Activity Limitations	Anticipated Duration
Non-Earner Benefits	Does the applicant suffer a complete inability to carry on a normal life? (i.e., Has the applicant sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Caregiver Benefits	As the Primary Caregiver, does the applicant suffer a substantial inability to engage in the caregiving activities in which he/she engaged at the time of the accident? (Primary Caregiver means that, at the time of the accident, the applicant was residing with a person in need of care and the applicant was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiver activities.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Lost Educational Expenses	Is the applicant, as a result of the accident, unable to continue in an elementary, secondary, post-secondary or continuing education program that the applicant was enrolled in at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Housekeeping and Home Maintenance Expenses	Does the applicant suffer a substantial inability to perform the housekeeping and home maintenance services that he or she normally performed before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
b) If you responded Anticipated Duration 'more than 12 weeks' to any disability test above, please explain why the task/activity limitations are likely to persist beyond 12 weeks.				

Part 8 Further Investigations or Consultations	a) Have there been any examinations, investigations, or consultations not previously reported by you? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify findings and results)
	b) Are further examinations, investigations or consultations contemplated or required? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)

**Part 9
Prior and
Concurrent
Conditions**

a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 7?
 No Unknown Yes (please explain)

If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury?
 No Unknown Yes (please explain)

If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident).

b) Since the automobile accident, has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability?
 No Unknown Yes (please explain)

**Part 10
Medications**

a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident.

Were these medications prescribed by you? No Yes

b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 9.

Were these medications prescribed by you? No Yes

**Part 11
Health
Practitioner
Signature**

Name of Health Practitioner		College Registration Number		You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist
Facility Name (if applicable)		AISI Facility Number (if applicable)		
Address				
City		Province	Postal Code	
Telephone Number		Extension	Fax Number	
Email Address				
I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.				
Name of Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)

Note: The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.