



Early Intervention Contact Sheet

Instructions for the Employer



The Disability Management Institute is authorized to collect, store, maintain and share personal information and does so in accordance with requirements of the Personal Information Protection and Electronic Documents Act (PIPEDA).

<p>Complete this form any time an employee has been, or will be, absent from work for five (5) consecutive days due to non-occupational illness or injury.</p>	<p>➔ Immediately send the form to DMI</p> <p>➔ Should you have any questions please call DMI</p>	<p>➔ Fax: 604-552-3648 or Toll free: 1-866-963-9994 Email: info@disabilityinstitute.com</p> <p>➔ BC/Alta/Sask Phone: 604-552-3647 or Toll free: 1-866-963-9995 Man/Ont/Atlantic Provinces Toll free: 1-866-459-3066</p>
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EMPLOYEE CONTACT INFORMATION			Please Print
Employer		Site / Location	
Last Name	First Name	Home Phone	
Alternate Phone	Personal Email Address	Work Email Address	
Address		Postal Code	
Position	Typical Shift Schedule / # hours per week	Interpreter Required	Language: <input type="checkbox"/> NO <input type="checkbox"/> YES
Is the employee eligible to apply for Short Term Disability benefits?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Policy	Class
Is the employee eligible to apply for Long Term Disability benefits?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Policy	Class
Does the employee have access to an Employee Family Assistance Program (EFAP)?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Specify EFAP Provider:	
Please specify, is the employee	<input type="checkbox"/> Union	<input type="checkbox"/> Non-union/excluded	<input type="checkbox"/> Management
Last Day Worked	Date First Absent	Date Faxed to DMI	Claim Category <input type="checkbox"/> Non-WCB <input type="checkbox"/> WCB

EMPLOYER CONTACT INFORMATION			Please Print
Employer Contact Name		Phone	
Employer/Manager would like to discuss absence with DMI?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
Doctor's note provided to employer?	<input type="checkbox"/> NO	<input type="checkbox"/> YES, If yes, please fax to DMI	
Has the employee provided an estimated return to work date?	<input type="checkbox"/> NO	<input type="checkbox"/> YES If yes, specify date below	
Has a Workers Compensation Claim been filed?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
Estimated (or actual) return to work date (Day/Month/Year)	Employer/Manager/Supervisor Signature		

**Please fax the completed form to DMI with doctor's note (if available).
Fax to 604-552-3648 or Fax Toll free to 1-866-963-9994**