MOHAWK SELF INSURANCE

MSI- 4

Safe Maternity Program Certificate for a Pregnant or Breast-Feeding Worker

(Please print clearly in ink)

SECTION A – WORKER INFORMATION S.I.N. _____

Worker's Name_____ Phone No._____
(Last name first, in full)

Address_____|__|__|__|__|__|__
(Street Number / P.O. Box) (City/Town) (Province) (Postal Code)

EMPLOYER:_____ Phone No._____

SECTION B – MEDICAL INFORMATION

Physician's Name_____ Phone No._____
(Last name first, in full)

Address_____|__|__|__|__|__|__
(Street Number and Name) (Apt. No.) (City/Town) (Province) (Postal Code)

Date of Examination: _____**Start Date of Leave:** _____

Patient's Occupation: _____ **Pregnancy due date:** _____

Description of medical condition which necessitates preventive withdrawal or re-assignment.

Please identify known work hazards which may potentially harm the patient or the unborn baby

What medical restrictions need to be considered in accommodating this worker in alternate work or modified duties?

How long will these medical restrictions be required?

I hereby Authorize any hospital, Physician, or other person who has attended me or the claimant to furnish to MSI or its representatives any and all information with respect to any illness or injury, medical history, consultations, prescriptions or treatment, and all copies of all hospital or medical records, a photo copy of this Authorization shall be considered as effective and valid as the original.. I hereby authorize the release to MSI any information requested in respect of this claim.
The furnishing of this form or its acceptance is not an admission of liability by MSI or a waiver of any conditions of the coverage. M.S.I. reserves the right to bring action to recover any benefit paid to an insured employee resulting from an accident caused by a third-party.
The beneficiary accepts to transfer all his rights to recover and authorize M.S.I. to enforce such rights in his/her name.

Worker's Signature:_____Date:_____

Physician's Signature: _____ Date: _____