Quebec Pan-Canadian Claimants' (PCC) Compensation Plan

PHYSICIAN FORM

CLAIMANT INSTRUCTIONS

Before You Use This Physician Form - Please Read Carefully

Do not submit documentation proving diagnosis unless it has been explicitly requested by way of a Notice from the Claims Administrator titled "**Notice to Provide Alternative Proof.**"

You do not need to use this Form if you have one of the following documents:

(i) For Lung Cancer or Throat Cancer: A copy of a pathology report confirming the diagnosis of Primary Lung Cancer or Primary squamous cell carcinoma of the larynx, oropharynx, or hypopharynx (Throat Cancer) between March 8, 2015 and March 8, 2019 (inclusive); or

(ii) For Emphysema or COPD (GOLD Grade III or IV): A copy of a report of a spirometry test (performed on the Tobacco-Victim between March 8, 2015 and March 8, 2019, inclusive) that first demonstrated a FEV1 (non-reversible) of less than 50% of the predicted value to first establish a diagnosis of Emphysema or COPD (GOLD Grade III or IV).

(iii) A copy of an extract from a medical file of the Tobacco-Victim confirming the diagnosis and date of diagnosis between March 8, 2015 and March 8, 2019 (inclusive).

If you have one of these documents, you do not need to complete this Form. This Form is meant to help only when the above-required medical records cannot be found.

Deadline to Submit this Physician Form: If you are relying on this Form as Alternative Proof of diagnosis and date of diagnosis between March 8, 2015 and March 8, 2019 (inclusive), you must submit this Form and all supporting documentation to the Claims Administrator as a complete package **by no later than the Deadline provided on your Notice to Provide Alternative Proof** by one of the following methods:

Securely Upload Online at: www.TobaccoClaimsCanada.ca

By email: info@TobaccoClaimsCanada.ca

By fax: 1-866-262-0816

By registered mail:

Tobacco Claims Canada
Claims Administrator
P.O. Box 2958 STN B
Ottawa ON K1P 5W9

PHYSICIAN FORM

The Tobacco-Victim or their Legal Representative should complete Sections I and II before giving this Physician Form to the Physician. Sections III to VI must be filled out and signed by a licensed physician.

Section I: Information regarding the Tobacco-Victim

(*To be completed and signed by the Tobacco-Victim or their Legal Representative*)

1. First Name of Tobacco-Victim: _____
2. Middle Name of the Tobacco-Victim (if applicable): _____
3. Last Name of Tobacco-Victim: _____
4. Date of Birth of Tobacco-Victim: _____
5. Tobacco-Victim's Provincial Health Insurance Number: _____

Section II: Authorization to Disclose Medical Information

(*To be completed and signed by the Tobacco-Victim or their Legal Representative*)

I understand that this Physician Form is being completed by a licensed physician to assist with a Claim under the PCC Compensation Plan.

I authorize the physician completing this Physician Form to disclose personal medical information about the Tobacco-Victim, including clinical history and/or diagnosis, directly on this Physician Form. This authorization is provided solely for the purpose of supporting the Claim and will not be used for any other purpose.

- ❑ I am the Tobacco-Victim;
- ❑ I am the Legal Representative of the Tobacco-Victim, authorized to act on their behalf.

Signed: _____ (Tobacco-Victim or Legal Representative)

Name (please print): _____

Date: _____

Section III: Name and Contact Information of Physician

(*To be completed and signed by a licensed physician*)

1. Full name of Physician: _____
2. Address of Physician: _____

   _____

   Business Phone: _____

   Business Email Address: _____
3. Preferred language of correspondence:
   - ❑ English
   - ❑ French

Section IV: Disease Diagnosis

1. Has the Tobacco-Victim been diagnosed with primary Lung Cancer, Throat Cancer (primary squamous cell carcinoma of the larynx, oropharynx, or hypopharynx), or Emphysema or COPD (GOLD Grade III or IV)?

   Check and provide the date of diagnosis for all that apply:

   - ❑ Primary Lung Cancer
     - ○ Date of Diagnosis

       _____

       (DD/MM/YYYY)
   - ❑ Throat Cancer (primary squamous cell carcinoma of the larynx, oropharynx, or hypopharynx)
     - ○ Date of Diagnosis

       _____

       (DD/MM/YYYY)
   - ❑ Emphysema or COPD (GOLD Grade III or IV)
     - ○ Date of Diagnosis

       _____

       (DD/MM/YYYY)

2. Please attach **at least one** of the following records that verify the above-referenced diagnosis and date of diagnosis:

❑ Pathology Report	❑ Biopsy Report	❑ MRI Report
❑ Operative Report	❑ CT Scan Report	❑ PET Scan Report
❑ X-ray Report	❑ Sputum Cytology Report	❑ Spirometry Report
❑ Extract from medical chart	❑ Any other medical evidence or documentation that establishes the diagnosis and date of diagnosis (list the records attached): _____	

_____

Please attach the requested medical documentation to verify the diagnosis. The request for documentation to confirm the diagnosis is a request for existing clinical records only. It is not a request for you or other physicians to prepare a report at this time.

Section V: Smoking History

Please answer the following question based upon information in the clinical records you have reviewed. This is not a request that you seek information from the Tobacco-Victim or claimant or perform an exhaustive review of the Tobacco-Victim's clinical records. The Tobacco-Victim or claimant is required to respond to questions regarding smoking history on a separate Claim Form which they will submit to the Claims Administrator. If this information is not readily available to you, select "Do not know".

1. To the best of your knowledge, information and belief, does or did the Tobacco-Victim smoke cigarettes?

   ❑ Yes

   ❑ No

   ❑ Do not know

Section VI: Certification by Physician

I certify that the information provided on this Physician Form is true and correct to the best of knowledge, information and belief.

_____ _____

Date Signed Signature of Physician