

1. Patient Identification

 Last Name First Name | Y | Y | Y | Y | | M | M | | D | D |
 Date of Birth

2. Information on the patient's disability

Nature of the disability: _____

According to the diagnosis, does the patient have a severe physical or mental disability?

No
Yes

Is the disability permanent?
No
Yes

Does the disability render the patient unemployable?
No
Yes

Will the patient eventually be able to resume their usual work?
No, why not: _____
Yes

In purely medical terms, can or will the patient be able to perform other work?
No, why not: _____
Yes

Comments regarding the prognosis, if applicable:

3. Signature

 Full name of physician (in block letters)

 Address

 City

 Province _____ Postal Code _____

Medical licence number: | | | | | | | | | | | | | | | |

Telephone: | | | | | | | | | | | | | | | |

I certify that the information provided in this attestation is correct.

 Physician's signature | Y | Y | Y | Y | | M | M | | D | D |
 Date

Submit documents

- ▶ **Complete and sign** the form electronically in the PDF document or print and fill in a hard copy. An electronic signature is accepted.
- ▶ See the types of signatures that are accepted in our **FAQ: fondaction.com/faq/types-signatures-admis**.
- ▶ Send the form and any other required document **or** **by mail:** Fondaction – Shareholder Services
2175 De Maisonneuve Blvd. East, suite 103,
Montréal, Québec H2K 4S3
through the secure online portal: www.fondaction.com/secure-location

Please note that we may ask you to provide additional information or documents, if needed.