SICK LEAVE PLAN

EMPLOYEE'S STATEMENT

To Be Completed By Employee / Email to Claims or call 250-364-4325

PART 1

Employee Name:		**Emp #:**	
Address:		Phone #: ( )	**Shift:**
		Date of Birth:	
		Occupation:	
Email:		Supervisor:	

PART 2

A	Is Disability due to *(please circle one)*:	HOSPITALIZATION	PROCEDURE	SICKNESS	ACCIDENT
	Date first unable to work due to disability:		Expected return to work date:		
	Has or will a claim be filed with Worksafe BC?			YES	NO
B	Physician / Medical Practitioner:		Physiotherapist:		
	Hospitalized?	YES NO	Date of First Visit:		
	Admission Date:		Discharge Date:		
C	Were you working for another employer during the period claimed?			YES	NO
	If yes, give details including source and amount of benefit:				

I declare all the information I have given on this report is true and correct. I understand to work and earn income while receiving Basic Sick Leave Benefits without advising Claims and Disability Management at Teck Metals Ltd., Trail Operations is not permitted.

Employee Signature:		***Date:***	