ALBERTA BLUE CROSS®

CONFIRMATION OF ILLNESS FORM

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms and any medical treatment you may have received for your condition.

Please complete and sign this form

POLICY NUMBER		IDENTIFICATION NUMBER	
LAST NAME		FIRST NAME	INITIAL
DATE OF BIRTH (DD-MM-YYYY)	TELEPHONE	CELL	

1. Date symptoms first appeared (DD-MM-YYYY)**:**	**First day absent from work** (DD-MM-YYYY)**:**

2. Please indicate the symptoms associated with your illness:

☐ Fever	☐ Decreased appetite	☐ Cough	☐ Vomiting
☐ Fatigue	☐ Nausea	☐ Muscle aches	☐ Shortness of breath
☐ Sore throat	☐ Headache	☐ Runny nose	☐ Other: _____

3. Do you have any other health problems that might affect your recovery (such as diabetes, heart disease or respiratory illness)?

4. What medical attention have you sought for your symptoms?

☐ None at this time—I'm following public health recommendations to stay at home.

☐ I've called my provincial health line, flu clinic or doctor's office for a telephone consultation.

Dates of consultation _____ *Name and phone number of services/clinic/physician* _____

What advice were you given regarding managing your illness? _____

☐ I have seen my physician, or have gone to a clinic or hospital for assessment.

Dates of visit _____ *Physician's name or name of clinic or hospital* _____

5. What advice were you given regarding managing your illness and/or treatment received?

Continued next page

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Continued from front

6. Date of COVID-19 test (DD-MM-YYYY)**:**

7. Name, address and phone number of facility where test was conducted:

Facility name	*Facility address*	*Facility phone number*

8. Test result:

☐ Positive

☐ Negative

☐ Pending –
if pending, date expected (DD-MM-YYYY): _____

Attach test result if available.

9. Have you been instructed to quarantine?

☐ Yes, as of this date (DD-MM-YYYY): _____

☐ No

When do you expect the quarantine to end?

_____

When are you next seeing your physician?

_____

10. When did you return to work? (DD-MM-YYYY)	**Or when do you expect to return to work?** (DD-MM-YYYY)

I certify that the statements in this form are true and complete and understand that further information may be required to validate my claim.	
SIGNATURE	DATE (DD-MM-YYYY)

For more information on the coronavirus, go to **https://www.albertahealthservices.ca/topics/Page16944.aspx** or the Public Health Agency of Canada's website at **http://www.phac-aspc.gc.ca/index-eng.php**.