HARMAC EMPLOYEES' MUTUAL BENEFIT ASSOCIATION

Application for EMBA Benefits

1000 Wave Place, Nanaimo, BC V9X 1J2

NAME		DATE
ADDRESS		TELEPHONE #
CITY	POSTAL CODE	POSITION

NATURE OF ILLNESS OR DISABILITY

WHEN DID IT OCCUR?	DID INJURY OCCUR AT WORK? ☐ YES ☐ NO	LAST SHIFT WORKED

NAME OF YOUR PHYSICIAN	ADDRESS OF PHYSICIAN

PHYSICIAN'S REPORT - DIAGNOSIS

WHEN DO YOU EXPECT THE EMPLOYEE WILL BE ABLE TO RETURN TO WORK?	DATE OF VISIT
	PHYSICIAN'S SIGNATURE
DATE RECEIVED BY COMMITTEE	EMBA COMMITTEE'S SIGNATURE

If I receive time loss payments from the Worker's Compensation Board, no-fault wage benefits, compensation or damages from an Insurance Carrier or from any person as a result of this disability or the incident causing same, I hereby agree to reimburse the EMBA Fund for any monies received from the Association, together with interest at the rates set from time to time pursuant to the Court Order Interest Act, R.S.B.C. 1979, Chapter 76. If I incur legal expenses in pursuing such claim for compensation or damages, I may deduct 20% from the total of such monies to be paid back to the EMBA Fund as partial reimbursement for my legal expenses (inclusive of all taxes).

I hereby authorize EMBA to contact any insurance Carrier or 3rd Party regarding my claim, in order to arrange for reimbursement directly to EMBA, in accordance with this reimbursement agreement I have signed.

I hereby assign such claim for time loss payments, no-fault wage benefits, or damages or compensation to the EMBA to the extent necessary to reimburse the EMBA Fund pursuant to this agreement. I authorize and irrevocably direct any solicitor having notice of this assignment to fully reimburse EMBA directly the amount required to be paid pursuant to this agreement before releasing any funds to me or for my benefit.

DATE	CLAIMANTS' SIGNATURE

WORKSAFE BC

HARMAC'S MODIFIED WORK PROGRAM

Harmac Pulp Operations has a modified work program for workers injured on or off the job. If medically suitable, we promote safe and productive work as an appropriate form of therapy

It is our intention to offer:________________________ work under our Disability Management Program.
The information you provide below will allow us to devleop a modified work program, if required, appropriate to this worker's physical limitations.

PHYSICIAN'S SECTION

Please circle the appropriate level of ability in accordance with your patient's physical limitations:

WALKING	Short distances Extensive	**STANDING**	Short periods long periods	**SITTING**	Some Long Periods
STAIRS	Occasionally Frequently	**LIFTING**	1-10 lbs. 10-20 lbs. 20+ lbs.	**MILL EXPOSURE**	Office Work Shop Work Tours of Areas Working in Mill

Any additional comments regarding your patient's physical limitations:

Does the employee require a reduction in their normal work hours: YES NO
If yes, how many hours per day? For how many days before returning to full-time duties

Do you wish to reassess before the employee recommences normal duties? YES NO

DOCTOR'S SIGNATURE________________________ DATE ________________________