COMPASSIONATE APPEAL – ATTENDING PHYSICIAN'S FORM

(Appeal due to Extreme Poverty or Sickness under Section 357. (1) (d.1) of the Municipal Act)

Personal health information on this form is collected under the authority of the Corporation of the City of Windsor. It is related directly to and needed to support the Tax Appeal Application under Section 357. (1) (d.1) of the Ontario Municipal Act.

SECTION 1: TO BE COMPLETED BY THE PATIENT (PLEASE PRINT)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex: ☐ M ☐ F

Birth date: ☐☐ / ☐☐ / ☐☐☐☐
DAY MONTH YEAR

PHYSICIAN INFORMATION

Physician's last name:	First:	Street address:	
City:	Province:	Postal Code:	Telephone number: ( )

Pursuant to S. 29 of PHIPA (Personal Health Information Protection Act), I (the undersigned patient) authorize and consent to the physician named on this form to disclose to the City of Windsor administrative staff authorized to administer and consider tax relief, personal health information as is necessary or as may be reasonably required by the City of Windsor to support my tax appeal application.

I understand that the City of Windsor will maintain and store this information in such a manner as to protect its confidentiality.

Signature of Patient:	Date: ☐☐ / ☐☐ / ☐☐☐☐ DAY MONTH YEAR

SECTION II: TO BE COMPLETED BY THE ATTENDING PHYSICIAN (PLEASE PRINT)

The above mentioned patient has filed a Tax Appeal Application for special consideration on medical grounds. The patient is authorizing you, the attending physician, to release the information requested below. Please retain a copy of this form for your files as your office may be contacted to verify that this statement was completed by the attending physician. The original form must be returned to the patient for submission with the application.

Date form received: ☐☐ / ☐☐ / ☐☐☐☐
DAY MONTH YEAR

PATIENT HISTORY

Date of illness/accident:

Start: ☐☐ / ☐☐ / ☐☐☐☐ DAY MONTH YEAR End: ☐☐ / ☐☐ / ☐☐☐☐ DAY MONTH YEAR

Summary of nature of illness/accident:

Has the illness/accident and/or treatment prescribed seriously affected the patient's ability to work and perform?
Yes ☐ No☐

If Yes, please answer both a and b:
a) In what way?

The information on this form is collected under the authority of section 357 of the Municipal Act, 2001 and it will be used only for the purposes of determining eligibility for property tax relief and the amount of tax relief in respect of the Tax Relief Application.

b) During what period of time?

In your opinion will the patient ever be able to resume any type of work? No❑ Yes ❑

If "Yes", what is the anticipated date of return to work?

☐☐ / ☐☐ / ☐☐☐☐
DAY MONTH YEAR

PRESENT CONDITION

At this date is the patient:

Ambulatory ❑ Bedridden ❑ Confined to House ❑ Hospitalized ❑ Other ❑ If "Other" please explain:

REMARKS

PHYSICIAN'S CONSENT

Signature of Attending Physician:	Date: ☐☐ / ☐☐ / ☐☐☐☐ DAY MONTH YEAR

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