PRACTITIONER STATEMENT FORM

(PARAMEDICAL OR MEDICAL SERVICES)

Crawford & Company (Canada) 100
Milverton Blvd - Suite 300
Mississauga, Ontario L5R4H1 O
+1-888-688-4344
equity@crawco.ca

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Name of Practitioner:	**License No.:**	
Address:		
City:	**Province:**	**Postal Code:**
Phone #: ( )		
Legal Name of Claimant:	**Claimant's Date of Birth:**	
CAEA Member No.:		
Describe symptoms/condition in detail:		
Indicate date of symptoms/condition:		
Describe type of treatment being administered:		
Reason for treatment:		
List all physical limitations:		

Signature of Practitioner ______________________ Date Signed ______________________

SUBMIT THIS FORM WITH ANY REQUIRED ATTACHMENTS TO:

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