BCTF Salary Indemnity Plan —Short-term
100-550 West 6th Avenue, Vancouver, BC V5Z 4PZ | Phone: 1-800-663-9163 | 604-871-1921 | Fax: 604-871-2287 | Email: benefits@bctf.ca

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ST—Accommodation employment application—Page 1 of 1

Complete this form if you are working a reduced assignment due to illness/injury, or volunteering, or returning to work on a gradual basis. You must provide the following information and submit it to the BCTF Salary Indemnity Plan Administrator for prior approval. See SIP Regulations 14 and 15.

Any approval by the BCTF, on behalf of the BCTF Salary Indemnity Trust, regarding a non-teaching or other accommodation while you are in receipt of benefits under the Salary Indemnity Plan does not provide any assurances that the non-teaching accommodation or volunteering is in alignment with your employer's policies and procedures regarding permissible activities during a medical leave. As a result, it is recommended that you consult your local union to determine whether you should seek your employer's permission to engage in the accommodation or volunteering while on medical leave.

Please print

Name: _____ **BCTF member ID:** _____

Nature of accommodation or volunteering duties:

☐ **Teaching—paid** ☐ **Non-teaching—paid** ☐ **Volunteering—unpaid** ☐ **Work-hardening—unpaid**

Start Date: _____ **End Date:** _____

Time: ☐ Full-time ☐ Part-time Percentage: _____ %; or hours/week: _____
(teaching) (non-teaching)

If part-time, which days? ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat/Sun

Full description of duties and activities. Use reverse side if necessary:

_____

_____

_____

Name of employer: _____ Phone: _____

Employer address: _____

Claimant signature: X_____ **Date:** _____
Note: Type name if completing online for authorization purposes.

All pay slips must be submitted monthly to report all income.

To be completed by physician

I support the: ☐ accommodation employment plan ☐ volunteer plan

commencing _____, as outlined above and certify that _____
Year Month Day name of patient

is still unable to undertake their normal employment duties.

Name of physician: _____

Signature of physician: X_____
Note: Type name if completing online for authorization purposes.

Date: _____
Year Month Day

Return completed form via:
Email: *benefits@bctf.ca*
Fax: 604-871-2287
Mail: 100–550 West 6th Ave
Vancouver, BC V5Z 4P2

Date received by BCTF Income Security