CHARTERED PROFESSIONAL ACCOUNTANTS BRITISH COLUMBIA

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MEDICAL FORM
CPD and/or DUES REDUCTION

MEMBER: Please fill in the top portion of the form and ask your physician to complete the remainder. Once it is complete, it should be returned to the address noted above or email to cpd@bccpa.ca or duesadjustments@bccpa.ca

Surname (*please print clearly)* _____ First and Middle names _____ Member ID # _____

PHYSICIAN TO COMPLETE THE FOLLOWING FOR THE ABOVE-NOTED CPABC MEMBER:

Does the member, in your professional opinion, suffer from an illness or condition that is sufficiently severe that it affects the member's ability to work? ☐ YES ☐ NO

When was the member first seen regarding this illness/condition? _____

Describe the impact of this illness/condition on the member's ability to work this calendar year: _____

If there is/was a period of time when the member is/was unable to work, please provide the range of dates (for each period). _____

Is the member able to work now? ☐ Yes ☐ No If yes, can the member work: ☐ PT ☐ FT

Do you anticipate that the member's ability to work will be affected on a continuing basis, and if so, for how long?

Physician's Name – (please print clearly) _____ Physician's Signature _____ Date _____

Physician's Address _____ Physician's Telephone # _____ Registration # _____

Information on this form is used solely to determine eligiblity for a reduction of member dues and/or CPD requirements. All information is kept strictly confidential.