COVID-19 Illness and Mandatory Self-Isolation Benefit Application Form

Purpose: To provide licensed physicians living and working in a self-employed practice in Saskatchewan with financial support during a self-isolation period due to COVID-19 illness and mandatory self-isolation, as a result of workplace exposure.

Name: _____ **City:** _____

Address: _____ **Postal Code:** _____

Email: _____ **Phone:** _____

A. Criteria - Please check yes for the following*:

☐ I am licensed with the College of Physicians and Surgeons of Saskatchewan under bylaw 2.4, 2.5, 2.6 or hold a locum license
☐ I am a resident of Saskatchewan and practicing in Saskatchewan
☐ I am self-employed
☐ I have been exposed to COVID-19 at work
☐ I have completed the SHA's Pandemic Exposure Status Form

*exceptions will be reviewed jointly by the SMA and Medical Services Branch of the Ministry of Health.

***B.* Time frame** *(Please note, benefit start date is April 6, 2020*)*

Date of illness/exposure: _____

Date of self-isolation: _____

Date of return to work: _____

C. Physician type

☐ Family Physician ☐ Specialist ☐ Other: _____

D. Compensation Method

☐ Fee-for-service ☐ Non Fee-for-Service

E. Payment Method

☐ Electronic Fund Transfer (EFT) (see page 2)

☐ Cheque: _____
(Personal or Corporation name)

Signature: _____ **Date:** _____

Return to:
Email: isolationbenefit@sma.sk.ca or Fax: Fax: 306 653 1631
Attention: COVID-19 Illness and Mandatory Self-Isolation Benefit

DIRECT DEPOSIT AUTHORIZATION FORM

Accountholder Name

Surname: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email address: _____

(A statement of what you are being paid for will be emailed to you once the payment is deposited successfully into your account. Please indicate the email address you wish to receive this electronic statement.)

Banking Information

Name of Financial Institution: _____
Branch Address:
_____

City: _____ Province: _____ Postal Code: _____

Branch Number (5 digits)

Institution Number (3 digits)

Account Number (maximum 12 digits)

Please attach a **sample voided cheque** for the bank account you wish us to credit.

I/we hereby authorize the Saskatchewan Medical Association to credit the Payee account indicated above (or another account which I/we may subsequently authorize).

Signature: _____ Date: _____

If the account is a joint account, that individual must also agree to the terms stated above by signing below.

Signature: _____ Date: _____