



### Health and Wellness Program—Referral form

Teacher's name:	Date received by BCTF Income Security Division
Address:	
City:	
Postal code:	
Member ID:	
Email:	
Home telephone:	SD #
Date of birth:	<input type="checkbox"/> Female <input type="checkbox"/> Male
School name:	School telephone:
Contract %	% working in current year:
Diagnosis (optional)	Number of sick days remaining:

Reason for referral: (select one box below)	
<input type="checkbox"/>	This full-time teacher has been absent from work for 20 consecutive working days.
<input type="checkbox"/>	This part-time teacher has not worked his/her allocated hours for four consecutive weeks.
<input type="checkbox"/>	This teacher has a reduced assignment due to disability.
<input type="checkbox"/>	This teacher is using sick days to manage his/her symptoms. (Non-consecutive use of sick leave—approximately 10 days in the current school year and 10 days in each of the past two [2] years.)
<input type="checkbox"/>	Other—please specify:

Referral source	
Date:	
Name :	Telephone:                      Ext.
Position:	<input type="checkbox"/> Local <input type="checkbox"/> School district
<b>Comments:</b>	
Local has discussed program with teacher? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Send referrals via fax to:  
BCTF Income Security Division  
Fax: 604-871-2287