



## CONSENT TO EXAMINATION

Name:
Claim Number:
Date of Birth:
Date of Accident:

I, the undersigned, do hereby consent to a psychiatric examination, medical history, and/or physical examination at my Medical Panel.

I understand that the information gained through this examination may form part of the consensus medical opinion being addressed by the Medical Panel.

I understand that the purpose of the examination is for evaluation only, and that **no treatment will be offered or undertaken**. I realize that **no traditional physician/patient relationship is established** during the course of this assessment.

I understand that my consent is voluntary, and that I can revoke my consent at any time before or during the examination.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_  
(Please print)

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

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**Toll Free:** 1-877-787-0622  
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