Alberta

Scarring Assessment (CF-SCR-1)

For accidents that occur on or after **January 1, 2027**

Part 1. Claimant Information

Last Name	First Name	Middle Name(s)

Mailing Address	City or Town

Province	Country	Postal Code	Email Address

Telephone Number	Date of Birth *(dd-mm-yyyy)*	Date of Accident *(dd-mm-yyyy)*

Policy Number (if known)	Claim Number (if known)

Insurance Company

Part 2. Health Care Practitioner Information

Full Name of Health Care Practitioner

Profession

Professional License or Registration Number

Mailing Address

City	Province	Country	Postal Code

Clinic Name	Administrative Contact's Full Name

Telephone Number	Fax Number

Email	Preferred Contact Method
	☐ Phone ☐ Email

Part 3. Scar Information (all measurements to be recorded in centimetres)

1. Scar

Scar Location	Scar Type (e.g., irregular, raised, or discoloured)

Scar Description

Scar Length	Scar Width

Specify if the scar is

☐ Conspicuous ☐ Inconspicuous ☐ Flat ☐ Faulty ☐ Presents with an alteration in form and symmetry

If applicable, describe impact of scare on functional impairment

If applicable, describe impact of scar on range of motion

Add scar

Part 4. Health Care Practitioner Signature

I certify that the information provided is true and correct to the best of my knowledge.

Full Name of Health Care Practitioner (Please Print)	Date Report Completed and Signed (DD/MM/YYY)	Signature

Notice for Statutory Authority to Collect and Disclose Personal Information
The *Automobile Insurance Act* authorizes the collection and disclosure of the personal information required by this document.

Please consult your privacy officer, legal counsel, or the Office of the Information and Privacy Commissioner of Alberta regarding any questions about your obligations under applicable privacy legislation.