

**EMERGENCY HOSPITAL & MEDICAL INSURANCE
FOR CANADIANS MEDICAL CERTIFICATE**

NOTE: This certificate must be fully completed by the licensed physician at the patient's destination who treated the injury/sickness resulting in this claim. Any fee charged for completing this form is the patient's responsibility.

Patient's First Name: _____ Last Name: _____

Date of Birth: **MM/DD/YYYY** Policy #: _____

Diagnosis/condition resulting in claim: _____

Date of first consultation: **MM/DD/YYYY** Date symptoms first appeared: **MM/DD/YYYY**

Date condition diagnosed: **MM/DD/YYYY**

Has the patient suffered from this medical condition in the past? Yes No

If 'Yes', please describe below the patient's history of this condition and other related conditions over the 12 months prior to this visit:

Date of Consultation	Diagnosis	Treatment Rendered
MM/DD/YYYY		
MM/DD/YYYY		
MM/DD/YYYY		

Please list the patient's existing medications prior to the visit: _____

Was the condition related to alcohol, misuse of drugs, or self-inflicted injury? Yes No If 'Yes', please provide details: _____

Was the patient hospitalized? Yes No Admission Date: **MM/DD/YYYY** Discharge Date: **MM/DD/YYYY**

Name of Hospital: _____

Was the visit related to pregnancy? Yes No

Date of last Menstrual Period: **MM/DD/YYYY** Expected Delivery Date: **MM/DD/YYYY**

Please provide the name and phone number of any other physicians who treated the patient, or referred the patient to you:

Name of other physician: _____ Telephone: () _____

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In your opinion, could the treatment for the above condition have been postponed until the patient's return to Canada? Yes No

If 'No', please provide medical criteria which would have prevented patient from travelling: _____

Please provide the date when the patient would have been able to travel: **MM/DD/YYYY**

PHYSICIAN'S CERTIFICATION AND SIGNATURE

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.

Physician's Signature: _____

Physician's Name (please print): _____

Date: _____ Email: _____

Street Address: _____

City/Town: _____ Postal Code: _____

Telephone: () _____ Fax: () _____

PHYSICIAN'S STAMP HERE