

EMERGENCY HOSPITAL & MEDICAL INSURANCE FOR CANADIANS MEDICAL CERTIFICATE

TIC Claims Department
1200 - 438 University Avenue
Toronto, ON, Canada M5G 2K8
Collect worldwide: 416-340-8809
Toll free Canada/U.S.A.: 1-800-869-6747

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		

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: () _____
Name of other physician: _____ Telephone: () _____

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: MM/DD/YYYY Email: _____
Street Address: _____
City/Town: _____ Postal Code: _____
Telephone: () _____ Fax: () _____

