



**MEDICAL CERTIFICATE**  
FOR EMPLOYMENT INSURANCE SICKNESS BENEFITS

**SECTION 1** THE CLAIMANT MUST COMPLETE THIS SECTION TO AUTHORIZE THE RELEASE OF THE INFORMATION REQUESTED IN SECTION (2) TO THE INSURER.

Social Insurance Number

Date of Birth

Y	M	D
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Last Name

First Name

Initials

Full Postal Address

Number and Street, Concession, Other	Apt. No.
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Area Code	Telephone Number
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City or Town
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Province / Territory	Postal Code
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I hereby authorize the release of all information related to my present illness and/or my pregnancy to the Insurer and to the insurer's medical examiner. Any charge for providing this information is my personal responsibility.

Signature of claimant, representative or next of kin

Y	M	D
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THE INFORMATION YOU PROVIDE ON THIS FORM IS COLLECTED UNDER THE AUTHORITY OF THE E.I. ACT AND WILL BE USED TO DETERMINE YOUR ELIGIBILITY FOR INCOME BENEFITS. THIS INFORMATION WILL BE RETAINED IN THE PERSONAL INFORMATION BANK ENTITLED "E.I. CLAIM FILE" (REGISTRATION NUMBER ESDC PPU 150). INSTRUCTIONS FOR ACCESSING YOUR PERSONAL INFORMATION ARE PROVIDED IN INFO SOURCE, A COPY OF WHICH IS AVAILABLE AT SERVICE CANADA CENTRES. YOUR PERSONAL INFORMATION IS PROTECTED AND ACCESSIBLE UNDER THE PRIVACY ACT.

**SECTION 2** MUST BE COMPLETED BY A **MEDICAL DOCTOR** OR OTHER HEALTH PRACTITIONER ACCEPTABLE TO THE COMMISSION

**PREGNANCY**

What is the expected date of confinement?

Y	M	D
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What was the actual date of confinement?

Y	M	D
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**INCAPACITY**

Date on which the above patient became unable to work due to their medical condition.

Y	M	D
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In my opinion, the above patient is incapable of working until:

Y	M	D
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COMMENTS:

Name of Medical Doctor (Print)

Speciality

Area Code Telephone Number

Address

Signature of Medical Doctor

Date

Y	M	D
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