Service Canada

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 (year month day)

Last Name

First Name

Initials

Full Postal Address

Number and Street, Concession, Other

Apt. No.

Area Code Telephone Number

City or Town

Province or Territory

Postal Code

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

Year Month Day

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 HRSDC 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? Year Month Day

What was the actual date of confinement? Year Month Day

INCAPACITY

In my opinion, the above patient is incapable of working until: Year Month Day

COMMENTS:

Name of Medical Doctor (Print)

Speciality

Area Code Telephone Number

Address

Signature of Medical Doctor

Date

Year Month Day

Service Canada delivers Human Resources and Skills Development Canada programs and services for the Government of Canada

GIVE THE COMPLETED FORM TO THE PATIENT

DISPONIBLE EN FRANÇAIS - INS 5140 F

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