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: ( ) _____

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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: MM/DD/YYYY _____ Email: _____

Street Address: _____

City/Town: _____ Postal Code: _____

Telephone: ( ) _____ Fax: ( ) _____

PHYSICIAN'S STAMP HERE

TIC claims & travel assistance