Service Canada

PROTECTED WHEN COMPLETED - **B**

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)

Last Name | First Name | Initials

Full Postal Address

Number and Street, Concession, Other | Apt. No.

Area Code Telephone Number

City or Town

Province / 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

Y M D

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)

What was the actual date of confinement? (Y M D)

INCAPACITY

Date on which the above patient became unable to work due to their medical condition. (Y M D)

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

COMMENTS:

Name of Medical Doctor (Print) | Speciality | Area Code Telephone Number

Address | Signature of Medical Doctor | Date (Y M D)

Service Canada delivers Employment and Social Development Canada programs and services for the Government of Canada

GIVE THE COMPLETED FORM TO THE PATIENT
DISPONIBLE EN FRANÇAIS - INS 5140 F

Canada