

MEDICAL CERTIFICATE

ocial Insurance Number	Date of Birth		D									
ast Name					Firs	st Name						Initial
lumber and Street, Concession, Other				Apt. No.		Area Co	ode Telephone	Number				
City or Town												
Province / Territory			Postal C	Code								
ne insurer's medical examiner. Any charge fo formation is my personal responsibility. HE INFORMATION YOU PROVIDE ON THIS COME BENEFITS. THIS INFORMATION WI 10). INSTRUCTIONS FOR ACCESSING YOU ENTRES. YOUR PERSONAL INFORMATION ENTRES. YOUR PERSONAL INFORMATION	FORM IS CC LL BE RETAIN UR PERSONA N IS PROTECT	LLECTED ED IN THE L INFORM ED AND A	E PERSON ATION ARE CCESSIBL	AL INFORMATION E PROVIDED IN <u>II</u> .E UNDER THE P	N BAI NFO RIVA	NK ENTIT <u>SOURCE</u> CY ACT.	LED "E.I. CLAIM A COPY OF W	I FILE" (REC HICH IS AV	GISTRAT AILABLE	ION NUM	BER ESD	C PPU
ECTION 2 MUST BE COMPLETED BY REGNANCY				HEALTH PRACT	HOP				51011			
Vhat is the expected date of confinement?	Y	Μ [)									
·····	Y	M [D									
			Expected Recovery Date									
hat was the actual date of confinement?	Expected Re	ecovery Da	te									
/hat was the actual date of confinement? NCAPACITY In my opinion, the above patient is icapable of working until:		,	te D									

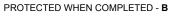
 Name of Medical Doctor (Print)
 Speciality
 Area Code Telephone Number

 Address
 Signature of Medical Doctor
 Date

 Image: Signature of Medical Doctor
 Y
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 Image: Signature of Medical Doctor
 Y
 M

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