Medical Certificate for Employment Insurance Compassionate Care Benefits

The Authorization to Release this medical information is a separate form and will be provided by the individual requesting that you complete this Medical Certificate for Employment Insurance Compassionate Care Benefits. This certificate and the Authorization form must be submitted together when a claim for compassionate care benefits is made.

Employment Insurance Compassionate Care benefits are available to eligible workers to provide care or support to a family member who is gravely ill with a significant risk of death within 26 weeks (patient).
For more information about the Compassionate Care Benefit, go to: www.hrsdc.gc.ca/en/ei/types/compassionate_care.shtml
Note: **For Employment Insurance benefit purposes, care or support is defined as:**
- **directly providing or participating in the care of the patient, or**
- **providing psychological or emotional support for the patient, or**
- **arranging for the care of the patient by a third party care provider.**

Important:
A Medical Practitioner (Health Practitioner other than a Medical Doctor) may complete this form when:
- the patient is in a geographical location where treatment by a Medical Doctor is not readily available **AND**
- the Medical Practitioner is designated by a Medical Doctor to provide treatment to the patient.

A. Patient's Name _____ **Date of Birth** _____ (d-m-y)

B. I last examined the patient on _____ (d-m-y) and certify that the following conditions exist:

1. The patient has a serious medical condition ***and*** a significant risk of death within the next 26 weeks (6 months).
Yes ☐ No ☐

2. The patient requires the care or support of one or more family members within this 6 months.
Yes ☐ No ☐

C. Compassionate care benefits are payable to eligible family members from the date in **B** above or the week this medical is signed. In some situations, these benefits are being requested for an earlier period of time and may be payable for this period if you certify that the 2 conditions in **B** above applied to your patient for an earlier period of time.

3. Did the two conditions in **B** above apply to your patient for an earlier period **within the past 6 months?**

Yes ☐ No ☐ If **yes**, please provide the earlier date _____ (d-m-y)

D. (If applicable)
In my professional opinion and to the best of my knowledge, the patient identified above is unable to give consent to the release of medical information because of his age, a physical or mental condition. **Yes** ☐

Signature (Medical Doctor or Practitioner designated by the Doctor) ▶ Date (d-m-y) ▶

Contact Information

Medical Doctor, or Medical Practitioner (Health Practitioner), designated by the Doctor (identified above)			
Name	Specialty		License No.
Apt no or suite no	Number and Street, Concession, Other	City or Town	
Province/Territory	Country	Tel. No. with Area Code	Postal Code (if in Canada)

Non-Canadian Doctors or Non-Canadian Medical Practitioners
Please provide the following information:
- the name of the university - the country and the year you obtained your certification
- your hospital or clinic affiliation and your license number

University	Country	Year
Hospital/Clinic Affiliation	License No.	