Medical Certificate for Employment Insurance Compassionate Care Benefits

- The information provided on this Certificate is collected by Human Resources and Skills Development Canada (HRSDC) under the authority of the Employment Insurance Act (EI), and is used to determine the eligibility for compassionate care benefits of one or more family members of a seriously ill individual.
- Failure to complete this form will result in family members not being entitled to receive compassionate care benefits.
- The information may also be used for policy analysis, research and/or evaluation purposes, in which case, various sources of information under the custody and control of HRSDC may be linked. In some instances, information may be disclosed without consent according to the EI Act.
- The personal information collected herein is administered in accordance with the EI Act and Privacy Act which states that individuals have the right to the protection of, and access to their personal information and have the right to request changes to incorrect information. It will be retained for six years after the last administrative action, as described in Personal Information Bank, Insurance Claim File - Local Office, HRSDC PPU 150. Instructions for obtaining this information are outlined in the government publication entitled Info Source, a copy of which is located at all Human Resources Centres. Info Source is also located at the following web site address: http://infosource.gc.ca.
- If you require clarification about this Statement, please contact our Privacy Coordinator at Privacy Co-ordinator by e-mail to nc-fas-sfa-atip-aiprp@hrdc-drhc.gc.ca or by calling (819) 994-0416 or writing to 140 Promenade du Portage, Phase IV, 1st Floor, Gatineau Quebec K1A 0J9.

Note:

- A Medical Doctor or other Medical Practitioner (Health Practitioner) may request a fee to fill out this certificate and Human Resources and Skills Development Canada (HRSDC) does not reimburse such fees.
- A last 26 weeks (6 months). claimant may avoid unnecessary costs by not submitting this certificate if one has already been submitted by any family member for the same patient in the

Section 1- PATIENT INFORMATION

If the patient is incapable of consenting to the release of medical information, Sections 1 and 2 must be completed by the patient's Legally Authorized or Appointed Representative, and the Medical Doctor or Practitioner must complete Section 3C.

Family name	All given names of the ill family member	Date of birth (d-m-y)

Residential address

Apt. no.	Number and Street, Concession, Other	City or Town

Province/Territory	Country	Postal Code (if in Canada)

I hereby authorize the release of the medical information shown in Section 3 to all family members claiming Employment Insurance (EI) Compassionate Care Benefits, as well as to HRSDC.

Signature ▶ Date (d-m-y) ▶

Section 2- PATIENT REPRESENTATIVE

To be completed by patient's legally authorized or appointed representative if, due to illness, Section 1 is not signed by patient.

Note: This section is NOT an authorization provided for or given pursuant to the EI Act to disclose patient information. HRSDC does not take any responsibility for, nor makes any undertaking in respect of, the lawfulness of anything stated in this section.

If the patient is unable to consent to the release of medical information, a person legally appointed or authorized by law to act on behalf of the patient and duly authorized by law to disclose patient information must read and sign the following:

Patient's Representative (Print Name)	Relationship to Patient in Kinship or Law	Tel. No. with Area Code

I am legally appointed or authorized to consent to the disclosure of this patient's medical information shown in Section 3.

The patient mentioned in Section 1 is at present unable to consent to the release of medical information.

I authorize the release of this medical information for no other purpose than to facilitate the completion of the medical certificate for Employment Insurance Compassionate Care Benefits. I have signed both sections 1 and 2 to authorize the release of information on this form.

Signature	Date (d-m-y)

Patient's Name	Date of birth (d-m-y)

Section 3- TO BE COMPLETED BY DOCTOR or MEDICAL PRACTITIONER

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.
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 Section 3 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. I last examined the patient mentioned in Section 1, 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 26 week period.**
Yes ☐ No ☐

B. Compassionate care benefits are payable to eligible family members from the date in A above or the week this medical is completed. In some situations, these benefits are being requested by family members for an earlier period of time.

Benefits may be payable for the earlier weeks requested if you certify that the 2 conditions in A above applied to your patient for an earlier period of time. Did these conditions apply to your patient for an the earlier period **within the past 6 months?**

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

C. (If applicable)
In my professional opinion and to the best of my knowledge, the patient identified in Section 1 is unable to give consent of release of the medical information because of a physical or mental condition. **Yes** ☐

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

Contact Information

Name of Medical Doctor, or Medical Practitioner (Health Practitioner) identified above, designated by the Doctor

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
- your license number

University	Country	Year

Hospital/Clinic Affiliation	License No.