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Island Breeze Trip Cancellation & Interruption Insurance Medical Certificate

Please note this certificate must be fully completed by a licensed physician who treated the injury/ sickness resulting in this claim. Any fee charged for completing this form is the patient's responsibility

Policy #: _____

Patients First Name: _____ Last Name: _____

Name of traveller, if different from patient: _____ Relationship to Patient: _____

Diagnosis/ condition resulting in claim: _____

Date Symptoms discovered/ appeared: MM: _____ DD: _____ YY: _____

Consultation Date: MM: _____ DD: _____ YY: _____

Date investigative testing began: MM DD YY

Diagnosis Date: MM: _____ DD: _____ YY: _____

Date Patient Made you aware of the Travel plans: DD MM YY

Are you the patient's usual family physician: Y N

If no please provide name, address and telephone number for patients usual family physician:

Name:

Address and Telephone Number:

Has the patient suffered from this medical condition in the past? ? Y N

if yes please list below the patient's history of this condition and other related conditions over the past 12 months prior to this visit:

Date of consultation	Symptoms Exhibited/ Diagnosis	Treatment Rendered
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Please provide a list of the patient's current prescription medications:

Was the condition related to alcohol, misuse of drugs, or self inflicted harm? Y N If "Yes" please provide more information:

Was Hospitalization Required: Y N Admission Date: MM: _____ DD: _____ YY: _____

Name of Hospital: _____

Was this hospitalization due to pregnancy? Y N

Expected Due Date MM: _____ DD: _____ YY: _____

Date of last Menstrual Period: MM: _____ DD: _____ YY: _____

Please provide the name(s) and contact information for any other physicians who have treated the patient, or referred the patient to you?

Name: _____ Telephone (____) _____

Name: _____ Telephone (____) _____

Date the patient was assessed as unfit to travel: MM DD YY Date you advised traveller not to travel MM DD YY

Physicians Certification & Authorization

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief

Physicians Signature: _____

Physicians Name: _____

Date:

MM: _____ DD: _____ YY: _____

Address: _____ City: _____

Postal Code: _____

Telephone: (____) _____ Fax: (____) _____

Physicians Stamp Here