



103, 8411, 200th Street
Langley, BC V2Y 0E7
TEL: (604) 888-0050
Toll free: 1(800) 993 6388
FAX: (604) 888-1008
International Fax: 001(604) 888-1008
E-mail: claims@sports-can.ca

Island Breeze Emergency Hospital & Medical Certificate for Canadians

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

Policy #: _____

Patients Given Name: _____ Last Name: _____

Date of Birth: MM: _____ DD: _____ YY: _____

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

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

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

Has the patient suffered from the same medical condition in the last twelve (12) months? Y N

If you answered "Yes" please provide all information about the condition and any other related conditions in the past 12 months prior to this consultation:

List any current medications the patient is taking:

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 (____) _____

Do you believe that the treatment for the above illness/injury could have been postponed until the patient was able to return to Canada? Y N

If "No" please provide the details preventing the patient to travel:

Please provide the date when the patient would have been able to travel: MM: _____ DD: _____ YY: _____

Physicians Certification & Authorization

I _____, verify that the information provided in this section is complete, true and accurate to the best of my knowledge.

Physicians Signature: _____

MM: _____ DD: _____ YY: _____

Address: _____ City: _____

Postal Code: _____

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

Physicians Stamp Here