



**MEDICAL CERTIFICATE
TRIP CANCELLATION AND INTERRUPTION INSURANCE**

TOUR+MED
247, Thibeau Blvd, Trois-Rivieres, Quebec G8T 6X9
Phone: (800) 268-9633 Fax: (819) 377-6069

ATTENDING PHYSICIAN'S CERTIFICATE

The licensed medical physician who treated the injury / sickness resulting in this claim must complete this certificate in full for all clinic, office, out-patient and short duration emergency room visits. Any fee for the completion of this form is the patient's responsibility

DOCTOR: Your certificate will establish the validity of the claim. Please complete fully. Applicable to the person whose condition was the cause of this claim.

Patient's Name: _____ Date of birth: _____
mm / dd / yyyy

Relationship to Insured: _____

Patient's Address: _____

Insured's Name: _____ Policy #: _____

Diagnosis related to claim: (List in order of severity)

1. _____
2. _____
3. _____

Date symptoms first appeared: _____
mm / dd / yyyy

Date of first medical consultation for present onset: _____ Date condition diagnosed: _____
mm / dd / yyyy mm / dd / yyyy

Is this a new condition? Yes No

If "No", on what date was this condition first diagnosed? _____
mm / dd / yyyy

Has patient received treatment or advice for this condition in the last year? Yes No

If "Yes", please provide all dates: _____

Does the patient take ongoing medication for this condition? Yes No

If "Yes", please provide names: _____

When was the medication last altered? _____
mm / dd / yyyy

Why? _____

Date medication first prescribed? _____
mm / dd / yyyy

Are you the patient's usual family physician? Yes No

If "No", please provide name, address and telephone number for patient's usual family physician:

Name: _____

Address and telephone #: _____

If patient was referred to you, provide name and phone number of referring physician:

Did the patient make you aware of travel plans? Yes No If "Yes", specify when: _____
mm / dd / yyyy

Did the patient receive medical approval from you for the trip? Yes No

If condition was due to pregnancy, what was the expected date of delivery: _____
mm / dd / yyyy

If condition was due to accident, what was the date of occurrence: _____
mm / dd / yyyy

Were follow up treatments required? Yes No Please specify dates: _____

Was the patient hospitalized? Yes No From _____ To _____
mm / dd / yyyy mm / dd / yyyy

Name of hospital: _____

Was the condition related to alcohol, misuse of drugs (prescription), or self-inflicted injury? Yes No

If "Yes", please provide details: _____

In your professional opinion, from what date did this condition preclude travel for the patient or a family member? _____
mm / dd / yyyy

On what date was the patient or family member advised to cancel the trip? _____
mm / dd / yyyy

If the two previous dates are different, please explain why: _____

Comments: _____

PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

Name of Attending Physician (please print): _____

Address: _____ City: _____

Province : _____ Country: _____ Postal Code: _____

Telephone : _____ Fax: _____

Email: _____

ATTENDING
PHYSICIAN'S
STAMP OR ATTACH
LETTERHEAD OR
PRESCRIPTION PAD

Signature of Attending Physician: _____ Date : _____