UV INSURANCE

CONFIDENTIAL MEDICAL CERTIFICATE

(To be completed by the attending physician)

□ **Cancer**	□ **Stroke**	□ **Heart Attack**
□ **Benign Brain Tumour**	□ **Paralysis**	□ **Heart Valve Replacement**
□ **Motor Neuron Disease**	□ **Loss of Independent Existence**	□ **Coronary Artery Bypass Surgery**
□ **Parkinson's disease**	□ **Loss of Speech**	□ **Aortic Surgery**
□ **Alzheimer's disease**	□ **Loss of Limbs**	□ **Deafness**
□ **Multiple Sclerosis**	□ **Kidney Failure**	□ **Burns**
□ **AIDS Infection**	□ **Blindness**	□ **Major Organ Transplant or Failure**
□ **Coma**	□ **Other:** _____	

Complete Patient Name: _____

Date of Birth: _____/_____/_____ (D / M / Y) **Policy Number:** _____

1. **Please indicate the extent and the severity of this illness:** _____
2. **Please indicate when the symptoms first appear for this illness:** _____/_____/_____ (D / M / Y)
3. **Please indicate the diagnostic date:** _____/_____/_____ (D / M / Y)
4. **When your patient has been informed of this diagnosis?** _____/_____/_____ (D / M / Y)
5. **Are you the regular attending physician of this patient?** Yes ❑ No ❑

   If yes**, please provide copies **of your records, surveys (i.e. magnetic resonance imaging, CT scan, lab results, electromyography, muscle biopsy, test chromosomes) diagnostics, consultation reports and summaries of hospitalizations.

   If no, please provide the full name and address of the patient's regular physician as well as the names and addresses of all consultants, specialists or hospitals where the patient was treated or relieved.

   _____
   _____
   _____
   _____

6. **Are there any notes on the recording family history of a related disease, or other related family history?**

   _____
   _____

7. **Describe the initial episode: nature, date and duration of acute symptoms.**

   _____
   _____

8. **Please detail the patient's habits and his medical history that could increase the risk or contributed to his condition.**

_____

_____

9. **Was a surgery required or is to be expected? If yes**, date and nature of the intervention.

_____

10. **Please detail the patient's habits about smoking, including according to your information and if so, how many the patient smoked cigarettes in the past and how many he smokes today.**

_____

_____

11. **Date of return to normal operations and / or physical and current mental limitations.**

_____

_____

12. **If you have other information of a medical nature that may help us in the evaluation of this request, please provide it.**

_____

_____

_____

Please include a copy of the file that you have COMPLETED for this person, including handwritten notes.

Name (print letters)**:** _____ **First name:** _____

Address: _____

Telephone Number: _____ **Specialty:** _____

X _____ _____

SIGNATURE **DATE**

Physician Stamp:

EQC071 (11-04)