

## Attending Physician Declaration Trip Cancellation

	Patient Information			
Name	First name	Gender	Date of birth	month da
Ir	nformation Concerning the Accident or Illness			
Diagnosis or natu injury or illness:	re of the			
Date the accident	t happened or first symptoms of the illness appeared:	month day		
Date of first consu	year month day ultation:			
Has this person e	ver suffered from this illness before?  Yes No			
f so, please speci	fy the date:			
Was the patient h	nospitalized due to this condition? Yes No			
f so, please speci	fy the dates: month day year to	month d ay		
s this condition the foo, please speci	fy:	month day		month day
f so, specify the r	referred to you by another doctor? Yes No  referral date:     Month day	Name and address of	the referring docto	r:
Medica	al Recommendation as to the Capacity of Travelling			
this patient the	person travelling?			
f so, was this pat	ient unable to travel due to this illness or injury? Yes	NO month day		
ndicate the date	on which you recommended the trip be cancelled:			
ates recommend	ded not to travel:   month day year month to   to	ear month o	day	
Are there any oth	ner reasons why this patient should not travel?			
	Comments			
	Physician Identification and Signature		Dhusisian's stance	
Name and address of the physician (Please print):			Physician's stamp	
Speciality:	Telephone:			
Date:	month day			

CanAssistance, Travel Claims Department: 1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9 - canassistance.com/en/policyholder/depot - Fax: 514-286-8409 or 1-800-210-0015