SCHEDULE H
Temporary Foreign Worker Program
MEDICAL DISABILITY, CHRONIC, OR TERMINAL ILLNESS CERTIFICATE

Part A – Certification of Medical Disability, Chronic or Terminal Illness

I, _____, hereby certify that
Full name of physician (please print)

_____, is currently experiencing a disability, chronic or
Full name of patient (please print)

terminal illness or other severe and prolonged physical and/or cognitive impairment that prevents him/her from attending to his/her normal daily activities/work.

_____ _____
Signature of physician Date (YYYY-MM-DD)

Part B – Requirements for Live-in Care

I, _____, am of the professional opinion, that as a result of
Full name of physician (please print)

the medical condition and on-going care needs of _____,
Full name of patient (please print)

certified in Part A, there is a requirement for access to a live-in caregiver, an employee who lives and works, providing personal care in the patient's private residence.

_____ _____
Signature of physician Date (YYYY-MM-DD)

Physician Information - Mandatory
Full name (please print)
Identification number
Province of Physician's Registration
Office Information
Number / Street / PO Box #
City
Province / Territory
Postal Code
Telephone number with area code