



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