Section D is to be completed by individuals who do not have proof of eligibility

D	**Authorization to disclose personal information for verification by a professional in the health and social services network**
I authorize the health care worker, whose name appears below, to confirm the information provided in section A for the sole purpose of accessing the CAL.	
First name of health worker	Last name of health worker
First name of applicant	Last name of applicant
Date of birth (YYYY-MM-DD)	
Signature of applicant or representative	
Date (YYYY-MM-DD)	

See the list of authorized health care workers in the guidelines document.

This authorization is valid for 90 days from the date of signature.

Section E must be completed by the health care professional

E Attestation by a health or social services professional

Based on the information available to me, I certify that the applicant, whose name appears below, requires support for the following reasons:

- ☐ Communicating with others
- ☐ Feeding themselves
- ☐ Completing activities safely
- ☐ Moving around
- ☐ Help with personal needs
- ☐ Orienting themselves

Considering that the CAL must be renewed every 5 years, will the applicant still have the same support needs in 5 years?

☐ To validate ☐ Yes ☐ No

If applicable, list any other pertinent information regarding their support needs:

First name of applicant	Last name of applicant
Date of birth (YYYY-MM-DD)	

First name of health worker		Last name of health worker	
Name of the institution			
Civic number	Street		Office
City		Province	Postal Code
Phone	Fax	Email address	
Signature of the professional		Date (YYYY-MM-DD)	
Profession		License No.	