



CERTIFICATE OF MEDICAL FITNESS MOBILE LICENSING

Personal information on this form is collected under the authority of the Municipal Act, 2001 and will be used for Business Licensing (or municipal By-law enforcement) purposes only. Questions about this collection should be directed to the City Clerk at the City of Markham (905) 477-7000.

IMPORTANT NOTICE

This Certificate of Medical Fitness will not be accepted if any of the requested data is not completed and/or if the examining physician's does not appear on this Certificate

SECTION ONE:

To be completed by the Applicant prior to visiting the Physician.

Applicant's Last Name	Applicant's First Name
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Street Number	Street Name	Suite/Apt. No.
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City/Town	Province	Postal Code
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Date of Birth (year/month/day)	Home Phone No.	Cell Phone No.
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SECTION TWO:

To be completed by the Examining Physician.

Name of Applicant: _____

This is to certify that I have examined the above individual on _____.

I am of the medical opinion that he or she is free from any communicable or transmittable diseases and is medically fit to operate a motor vehicle carrying passengers for hire.

To Attending Physician:

Please ensure that your patient has completed ALL of Section One to you signing this documents. Patient information cannot be added by the patient after the examination. If you have any questions, please contact the Licensing at (905) 479-7782.

Date of Examination

Signature/Stamp of Attending Physician



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