

# Certificate of Medical Fitness (Mobile Licensing)



City of Mississauga  
Transportation and Works Department  
Enforcement Division, Mobile Licensing  
3235 Mavis Road, Ground Floor  
Mississauga ON L5C 1T7  
Telephone No. 905-615-4311  
Fax No. 905-615-4486  
[www.mississauga.ca/enforcement](http://www.mississauga.ca/enforcement)

Personal information on this form is collected under the authority of sections 11, 150, 151, and 156 of the Municipal Act 2001, and City of Mississauga By-Law #420-04, as amended. The information will be used to license, regulate and govern owners and drivers of Taxicabs and the business of Taxicab Brokers and for the administration of the Public Vehicle Licensing Program. Questions regarding the collection of this information should be directed to the Manager, Mobile Licensing Enforcement, 905-615-4311 ext. 5573.

## **IMPORTANT NOTICE**

**This Certificate of Medical Fitness will not be accepted if not fully completed and/or if not signed by the examining physician. Return this Certificate with your completed Application.**

### **Section One**

#### **To be completed by the applicant prior to visiting physician**

Applicant's Name: Last		First	
Address: Street Number	Street Name		Apt./Unit #
City	Province		Postal Code
Home Phone #		Date of Birth (year/month/day)	

### **Section Two**

#### **To be completed by the examining physician**

- ☐ **Drivers of Vehicles for Hire**  
(Taxicab, AMTV, APTV, Limousine, Refreshment Vehicle)

This is to certify that I have examined the above mentioned person on 

YYYY	MM	DD	

I am of the medical opinion that ☐ he ☐ she is physically fit to operate a motor vehicle.

#### ***Dear Attending Physician:***

*Please ensure that your patient has completed ALL of Section One prior to you signing this document. Patient information cannot be added by the patient after the examination. Thank you.*

*If you have any questions, please do not hesitate to contact Mobile Licensing at 905-615-4311.*

Examining Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Business Phone \_\_\_\_\_

Signature of Examining Physician

YYYY	MM	DD	

### **Section Three (for office use only)**

Received

Staff Initials