Medical Certificate of Health
Taxicab Driver

Municipal Law Enforcement and Licensing Services
50 Centre Street South, Oshawa, ON L1H 3Z7

Driver's Information

Surname ***(Please print)***	Forename(s)	☐ Male ☐ Female

Permanent Address	Street and Number			Telephone Number
	City	Province	Postal Code	E-mail Address

I hereby authorize the City of Oshawa to make any investigation regarding this application and authorize release of the records and information to the City of Oshawa provided such information is received and discussed confidentially.

Signature	Date

Certification *(must be signed by person licensed to practice medicine in Ontario)*

☐ I have examined the individual noted above.

☐ Patient appears free of communicable disease.

☐ Patient appears to be medically and mentally fit for the purposes of a Taxicab Driver.

I hereby certify that the information on this form is correct to the best of my knowledge.

Physician's Signature	Date
Physician's Name (Last, First, Middle) ***(Please print)***	Telephone Number
Address	Postal Code

Personal information contained on this form is collected under the authority of the *Municipal Act* and will be used by the City of Oshawa in determining suitability for issuance of a licence.