

# 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  
 Bus. Hours: 8:30 a.m. to 4:00 p.m.  
 Monday to Friday  
[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
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YYYY				MM		DD			

### Section Three (for office use only)

Received	Staff Initials
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