

# Certificate of Medical Fitness

(Business Licensing)



City of Mississauga  
 Transportation and Works Department  
 Enforcement Division, Business Licensing  
 300 City Centre Drive, Ground Floor  
 Mississauga ON L5B 3C1  
 Telephone No. 905-615-4311  
 Bus. Hours: 8:30 a.m. to 4:30 p.m.  
 Monday to Friday  
 www.mississauga.ca/enforcement

Personal information on this form is collected under the authority of Section 155 of the Municipal Act 2001, c.25 and City of Mississauga By-Laws, as will be used for the purpose of issuing a municipal licence. Questions regarding the collection of this information should be directed to the Manager, Compliance and Licensing, 905-896-5558.

### 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															
<input type="checkbox"/> <b>Attendant's Licence</b>															
This is to certify that I have examined the above mentioned person on <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">YYYY</td> <td style="text-align: center;">MM</td> <td style="text-align: center;">DD</td> <td colspan="4"></td> </tr> </table>									YYYY	MM	DD				
YYYY	MM	DD													
I am of the medical opinion that <input type="checkbox"/> he <input type="checkbox"/> she is medically free from any communicable or transmittable diseases.															
<p><b>Dear Attending Physician:</b>          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.</p> <p>If you have any questions, please do not hesitate to contact Business Licensing at 905-615-4311.</p>	Examining Physician's Name _____ Address _____ Business Phone _____														
Signature of Examining Physician <div style="border: 1px solid black; height: 40px; width: 600px; margin-top: 5px;"></div>	<table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">YYYY</td> <td style="text-align: center;">MM</td> <td style="text-align: center;">DD</td> <td colspan="4"></td> </tr> </table>								YYYY	MM	DD				
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Section Three (for office use only)	
Received	Staff Initials