



Taxicab Driver's Certificate of Health

Taxicab Licensing By-law 6702/06

This form is to be completed by a duly qualified medical practitioner upon completion of a physical examination of the applicant. Please ensure that this form is completed in full and is signed and stamped by the medical practitioner.

Applicant Information

Surname of Applicant	Middle Initial	Given Name	
Present Address		Unit No.	Postal Code
Telephone Number	Sex	Date of Birth	

Health History

Diseases of the senses (deafness, vertigo, visual deficiencies, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cardiovascular diseases (heart failure, angina, infarction, embolism, arrhythmia, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Respiratory diseases (asthma, chronic bronchitis, emphysema, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diseases of the musculo-skeletal system (fractures, amputations, arthritis, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Metabolic diseases (diabetes (+)(-), hypoglycaemia, thyroid, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Psychiatric disorders (psychoneurosis, psychosis, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Addictions (alcohol, sedatives, tranquilizers, narcotics, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Neurological diseases (seizures, multiple sclerosis, dementia, head injury, mental retardation, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Communicable diseases (tuberculosis, hepatitis, small pox, meningitis, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Other diseases (blackouts, fainting spells, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does the applicant have any medical condition that may affect the applicants ability to comply with the physical requirements of this position?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If any of the questions above were answered YES, please explain below,

Signature of Duly Qualified Medical Practitioner	Date of Examination
Medical Practitioners Stamp or Seal	Release of Medical Information I consent to the release of this information to the City of Pickering for the purpose of determining suitability for licensing. Furthermore, I acknowledge that any fee required for a medical examination is not the responsibility of the City. Questions about the collection of this information may be referred to the City Clerk, One The Esplanade, Pickering, ON. City of Pickering Clerk's Division, 905.420.4611
	Signature of Applicant
	Date