TLC Medical Certification Form

MEDICAL EXAM REQUIREMENT

This form must be completed, signed, and stamped by a licensed physician. No other form can be used or will be accepted.

The date of the examination cannot be more than ninety (90) days prior to the date you submit your application.

Name of applicant: _____ **Date of exam:** _____ dd / mm / yyyy

Medical fitness determination

◯ is medically fit to safely operate a TLC-licensed vehicle ◯ is not medically fit to safely operate a TLC-licensed vehicle

Physician's Last Name, First Name: _____

_____

Physician's Signature

Number & Street (Mailing Address): _____ **Physician's License #:** _____

City, State, and Zip Code: _____

State in which the Physician is licensed:

Phone#: _____