Doctor or Nurse Practitioner's Certification

Instructions:

- **This page is to be completed by a medical doctor or nurse practitioner only.**
- **Once completed, return this page to the patient to submit with their application.**

Applicant Information – Enter the name of the patient registering for the Fuel Tax Refund Program.

LAST NAME	FIRST NAME	MIDDLE NAME (*if applicable*)

To be eligible for this program, your patient must qualify for at least one of the following conditions:

***Check* (✓) *all that apply* – DO NOT CHANGE OR AMEND QUALIFICATIONS**

1 ☐ Loss of a limb

2 ☐ Permanent dependence upon a wheelchair

3 ☐ Permanent functional loss of the lower limbs

4 ☐ Permanent impairment of movement to the extent that the use of public transportation by the person would be hazardous (whether or not public transportation is available)

5 ☐ Permanent mental disability to the extent that the use of public transportation by the person would be hazardous (whether or not public transportation is available)

6 ☐ Permanent sight impairment to the extent that the person is not eligible to hold a driver's licence under the *Motor Vehicle Act*

DISABILITY START DATE
YYYY / MM / DD

START DATE OF THE ABOVE MEDICAL CONDITION

Doctor or Nurse Practitioner's Certification – I certify that, to the best of my knowledge, the above information is true and correct.

Check (✓) one: ☐ I am a Doctor ☐ I am a Nurse Practitioner

NAME OF DOCTOR OR NURSE PRACTITIONER (*please print clearly or use a stamp)*	TELEPHONE NUMBER ( )
	FAX NUMBER ( )

ADDRESS OF DOCTOR OR NURSE PRACTITIONER (*include street or PO box, city and province*)	POSTAL CODE

SIGNATURE OF DOCTOR OR NURSE PRACTITIONER	DATE SIGNED YYYY / MM / DD
X	

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