

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 <i>(if applicable)</i>
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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
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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 <i>(print clearly or use a stamp)</i>	TELEPHONE NUMBER ()
	FAX NUMBER ()
ADDRESS OF DOCTOR OR NURSE PRACTITIONER <i>(include street or PO box, city and province)</i>	POSTAL CODE
SIGNATURE OF DOCTOR OR NURSE PRACTITIONER X	DATE SIGNED YYYY / MM / DD