City of Springfield Taxi Commission

MEDICAL CERTIFICATION FORM

This is to certify that I have examined_____
The applicant for a City of Springfield Taxi license on _____
(Examination must have taken place within the last six (6) months) Based on my examination reported herein, it is my opinion that she/he:

_____Is medically **fit** to safely operate a Taxicab.

_____Is medically **not fit** to safely operate a Taxicab.

_____
Physician's Last Name, First Name (printed)

_____
Physician's Signature

_____
Physician's Phone # Physician's license #

_____
Physician's Street Address,

_____
City, State, Zip code