Fisheries and Oceans Canada | Pêches et Océans Canada

MEDICAL FORM
SUBSTITUTE OPERATOR REQUEST

Part A – To be completed by the licence holder

Information about the person with the impairment (please print):

First name and initial _____ Last Name _____ FIN _____

Street No. and street name _____ City _____ Province _____

Postal Code _____ Date of Birth _____ Signature of licence holder _____

Substitute operator and licence information (please print):

First name and initial _____ Last Name _____ FIN _____

Species _____ Licence Number(s) _____

Part B – To be completed by the qualified medical doctor (please print)

Specific effects of impairment:

_____

_____

_____

_____

_____

Duration of impairment: From: _____ (YYYY-MM-DD) To: _____ (YYYY-MM-DD) Please be specific

I certify that to the best of my knowledge the information given in Part B of this form is correct and complete and I understand that this information will be used by Fisheries and Oceans Canada to determine if my patient is eligible for substitute operator status on his/her commercial fishing licences

Doctor's signature _____ Doctor's printed name _____

Date _____ Telephone _____