**REQUEST FOR VERIFICATION OF MEDICAL PRACTITIONER**
**(To be completed by the Applicant)**

**DATE:**_____

**NAME OF APPLICANT:**_____

**ADDRESS OF APPLICANT IN CANADA:**_____

**CONTACT TELEPHONE NUMBER IN CANADA:**_____

**DEPARTMENT TO BE ADDRESSED:**_____

**DOCTOR'S NAME, ADDRESS AND TELEPHONE CONTACT:**_____

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**SIGNATURE OF APPLICANT**

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**INSTRUCTIONS**: Applicants **MUST** submit the **ORIGINAL** Medical Certificate from the Doctor together with the completed form above by mail.