Fisheries and Oceans Canada | Pêches et Océans Canada

MEDICAL SUBSTITUTE OPERATOR FORM

Part A – To be completed by the licence holder

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

First name and initial	Last Name	FIN
_____	_____	_____

Street No. and street name	City
_____	_____

Province	Postal Code	Date of Birth
_____	_____	_____

I request that the following registered fisher be named as my substitute operator for the following duration:

Commencing date:_____ **Ending date:** _____

Signature: _____ **Date:** _____

<u>Substitute operator and licence information (please print)</u>:

First name and initial	Last Name	FIN
_____	_____	_____

Species	Licence Number
_____	_____

Part B – To be completed by the qualified practitioner (please print). Note: If you are only changing sub operators and have already submitted a Doctor's certificate for this disability, please provide a copy of the original.

Effects of impairment:

_____
_____
_____

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

Certification (check the box that applies to you):

☐ General Practitioner
☐ Occupational/physical therapist
☐ Physiotherapist
☐ Optometrist/opthamalogist
☐ Speech-language pathologist
☐ Other (please specify)
☐ Audiologist

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 DFO to determine if my patient is eligible for substitute operator status on his/her commercial fishing licences

Sign here	Print your name here
_____	_____

Date	Telephone
_____	_____

Address:

DFO Regional Licensing: 902-426-5010 (Fax)
E-mail: licence.maritimes.permis@dfo-mpo.gc.ca