

Medical Examination Report (Optional)

Medical examination is compulsory for every applicant who answered “Yes” to medical conditions that may render him/her unfit to drive safely. You may go to any clinic to have your medical examination completed by a qualified Medical Examiner:

Name of Applicant:

Age:

IC No:

Gender:

Race:

Section 2 - General Medical Examination (To be completed by Medical Examiner only)

Section 1 - Medical History / Tests (To be completed by Medical Examiner only)

Do you have any history or are you suffering from:	✓	✗	Medical Examiner's Remarks
1. Nervous Breakdown or Mental Trouble			
2. Severe headaches or migraines			
3. Fits or convulsions of any kind			
4. Fainting attacks or giddiness			
5. Head injuries or concussions	<input checked="" type="checkbox"/>		
6. Eye trouble of any kind (Note: Standard acuity should be at least 6/12 each eye, with or without optical aids)			Visual acuity with/without* glasses: Distance: RE /LE Near Vision: RE /LE
7. Color Blindness			Ability to identify Red/Green/Amber*
8. Difficulty in seeing in the dark			
9. Deafness			
10. Asthma			
11. Heart diseases, weak or strained heart			
12. Palpitations or breathlessness			Chest X-ray/CT Scan (as needed)
13. Physical or mental disability			
14. Illness or injuries not mentioned above			Please specify:
15. I have undergone a surgical operation			Please Specify:

1. Any deformity and/or physical disability observed			
2. Any evidence of wound/injuries or operations			
3. Any abnormality of movement of joints			
4. Any evidence of abnormality of nervous system			
5. Any evidence of psychiatric disorder			
6. An evidence of cardiovascular abnormality			
7. Any defect of hearing			
8. Any evidence of being addicted to alcohol or drugs			
9. Blood pressure normal for his/her age range?			BP: Systolic: Diastolic:

Overall Result (To be completed by Medical examiner only)

I certify that I have on this day examined the above applicant. The answers to the questions are correct to the best of my knowledge. I find the applicant physically and mentally FIT/UNFIT* to drive a vehicle for public service. Additional remarks (if any):

Name:

Qualification

Date:

Name of Hospital/Clinic:

Address of Hospital/Clinic:

Signature of Medical Examiner: