MEDICAL CERTIFICATE

APPLICANT'S INFORMATION

NAME: ____________ ____________ ____________
SURNAME FIRST NAME MIDDLE NAME

ADDRESS: ____________

SP / DL / CL NUMBER: ____________ DATE OF BIRTH: ____________

NATIONALITY: ____________ AGE: ______ GENDER: ______ MARITAL STATUS: ______

OCCUPATION: ____________

PHYSICAL INFORMATION

GENERAL PHYSIQUE
- ☐ Normal
- ☐ With Disability, pls specify ____________

HEIGHT: ______ (cms) WEIGHT: ______ (kgs)

CONTAGIOUS DISEASE
- ☐ None
- ☐ With Disease, pls specify ____________

BLOOD PRESSURE ______

BLOOD TYPE ______

EYE COLOR ______

UPPER EXTREMITIES:

LEFT	RIGHT
☐ Normal	☐ Normal
☐ With disability	☐ With disability
☐ With special equipment	☐ With special equipment

LOWER EXTREMITIES:

LEFT	RIGHT
☐ Normal	☐ Normal
☐ With disability	☐ With disability
☐ With special equipment	☐ With special equipment

VISUAL TEST

Visual Acuity:

LEFT EYE: SNELLEN/BAILEY-LOVIE: ____________
- ☐ With corrective lens
- ☐ Color blind

RIGHT EYE: SNELLEN/BAILEY-LOVIE: ____________
- ☐ With corrective lens
- ☐ Color blind

Glare/Contrast Sensitivity Function	**RIGHT EYE**	**LEFT EYE**
Without Lenses	______	______
With Corrective or Contact Lenses	______	______

Color Blind Test: ____________

ANY EYE INJURY OR DISEASE? (Specify)

____

IS FURTHER EYE EXAMINATION SUGGESTED?

☐ YES ☐ NO

AUDITORY TEST

LEFT EAR:	RIGHT EAR:
☐ Normal	☐ Normal
☐ Reduced	☐ Reduced
☐ With hearing aid	☐ With hearing aid

ASSESSMENT

- ☐ Fit to drive
- ☐ Unfit to drive
  - ☐ Permanent
  - ☐ Temporary Duration ______
  - ☐ Refer to Specialist for further Evaluation

METABOLIC AND NEUROLOGICAL DISORDERS

☐ YES ☐ NO **DIABETES**

Is it under proper control & medication? ☐ YES ☐ NO ____________ (Specify)

☐ YES ☐ NO **EPILEPSY** Date of last seizure ____________

Is it under proper control & medication? ☐ YES ☐ NO ____________ (Specify)

☐ YES ☐ NO **SLEEP APNEA**

Is it under proper control & medication? ☐ YES ☐ NO ____________ (Specify)

☐ YES ☐ NO **AGGRESSIVE, MANIC OR DEPRESSIVE DISORDER**

Is it under proper control & medication? ☐ YES ☐ NO ____________ (Specify)

☐ YES ☐ NO **OTHER MEDICAL CONDITION OR IMPAIRMENT WHICH MAY AFFECT ABILITY TO DRIVE SAFELY**

____

Is it under proper control & medication? ☐ YES ☐ NO

CONDITIONS

- ☐ None
- ☐ Wear Corrective Lenses
- ☐ Drive Only with Special Equipment for Upper Limbs/Lower Limbs
- ☐ Drive Customized Motor Vehicle Only
- ☐ Daylight Driving Only
- ☐ Hearing Aid is Required

PHYSICIAN ____________

PRC LICENSE NUMBER ____________

PTR NUMBER ____________

ISSUED AT ____________

CERTIFICATE # ____________

LTO CLIENT ID ____________

Signature ____________

Remarks :

DATE ISSUED: ____________

THIS MEDICAL CERTIFICATE IS VALID UNTIL ____________
(60 DAYS FROM DATE OF ISSUE)