



# Form "B"

(SEE SECTION 4 (2) ,SECTION 7(3) AND SECTION (15)  
National Identity Card Number



					-									
--	--	--	--	--	---	--	--	--	--	--	--	--	--	--

Form of Medical Certificate in respect of application for a license to drive any transport vehicle or to drive any vehicle as paid employee or otherwise

## TO BE FILLED IN BY REGISTERED MEDICAL PRACTITIONER

1. What is apparent age of the applicant? \_\_\_\_\_
2. Is the applicant; to best of your judgement subjected to epilepsy, vertigo chronic ill - health likely to effect his / her efficiency? \_\_\_\_\_
3. Does the applicant suffer from any heart or lung disordered which might effect the performance of his/her duties as a driver? \_\_\_\_\_
4. Does the applicant suffer from a degree of deafness which would prevent his/her hearing of ordinary sound signals? \_\_\_\_\_
5. Does the applicant have any deformity or loss of members, which effect the performance of his/her duties as a driver? \_\_\_\_\_
6. Does the applicant possess any evidence of being addicted to the excessive use of alcohol tobacco or drugs? \_\_\_\_\_
8. In your option; he/she is generally fit as regards (a) bodily in health? \_\_\_\_\_
9. Marks of identification \_\_\_\_\_
10. Blood Group \_\_\_\_\_

I certify that to the best of my information and belief the applicant **Mr/Ms/Mrs** \_\_\_\_\_ is the person here as above described and that the attached photograph is a reasonably.

### **Medical Officer**

Signature, .....

Name, .....

R.M.P.No., .....

CNIC, .....

Email, .....

Photo

1. Is there any defect of sightedness, if so, has it been corrected by using suitable spectacles? \_\_\_\_\_
2. Do you suffer from color blindness or night blindness? \_\_\_\_\_
3. In your option; he/she is generally fit as regards (b) eyesight? \_\_\_\_\_

### **Eye Specialist**

Signature, .....

Name, .....

R.M.P.No., .....

CNIC, .....

Email, .....