

Vehicle & Transit Licensing Group
 10 Sin Ming Drive Singapore 575701
 Tel: 1800 – CALL LTA (1800 – 2255 582) Fax: (65) 6553 5329

MEDICAL EXAMINATION REPORT
(VOCATIONAL LICENCE APPLICATION / RENEWAL)

Section A: Particulars of Applicant

| | | | |
|-----------------------------|--|-----------------|--|
| Name of Applicant: | | | |
| NRIC No: | | Contact Number: | |
| Type of Vocational Licence: | | | |

Section B: X-ray Examination (Certified by Radiologist) – (Only applicable to new applicants or if instructed by LTA).

I have had the applicant X-rayed, having assured myself that he/ she is the person named above by having had his/ her Identity Card/Work Permit examined and his/ her signature below.
 Please tick in the appropriate box

Result: There is no radiological evidence of chest lesion.
 The applicant is suffering from TB.

Comments, if any: _____

Date: _____

 Signature of Applicant
 (In the presence of the Radiographer)

 (Name and Signature of Radiologist)

Section C: Medical History (To be completed by Medical Examiner only)

Please tick in the appropriate column.

| Do you have any history of or are you suffering from: | Yes | No | 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 | | | |
| 6 Eye trouble of any kind | | | |
| 7 Colour blindness | | | |
| 8 Difficulty in seeing in the dark | | | |
| 9 Deafness | | | |
| 10 Asthma | | | |
| 11 Heart diseases, weak or strained heart | | | |
| 12 Palpitations or breathlessness | | | |
| 13 Physical or mental disability | | | |
| 14 Illness or injuries not mentioned above (please specify) | | | |
| I have undergone a surgical operation. | | | |

I declare that I have carefully considered the statements made above and they are, to the best of my knowledge, true and correct. I also declare that I have not withheld any relevant information or made any misleading statement. I give my consent to the examining or assessing Medical Examiner to communicate with any physician who has attended to me.

 Signature of Applicant & Date
 (In the presence of the Medical Examiner)

 Name/ Signature of Medical Examiner & Date

Section D: General Medical & Laboratory Tests (To be completed by Medical Examiner only)

| Test | | Medical Examiner's Remarks | | | |
|------|--|----------------------------|---|----|--|
| 1 | Colour Perception – is the applicant able to accurately identify the colours red, green and amber? | Yes | / | No | |
| 2 | Visual Acuity for distance | | | | |
| | ▪ * With / Without glasses | RE | | LE | |
| 3 | Near Vision | | | | |
| | ▪ * With / Without glasses | RE | | LE | |

In my opinion, the applicant *needs to / need not wear glasses when driving.

Note: The standard of acuity of vision should be at least 6/12 in each eye, with or without optical aids.

Comments, if any: _____

Section E: General Medical Examination (To be completed by Medical Examiner only)

Please tick in the appropriate column.

| | | Yes | No | Medical Examiner's Remarks |
|----|--|-----------|----|----------------------------|
| 1 | Any deformities and/or physical disabilities observed | | | |
| 2 | Any evidence of wounds/injuries or operations | | | |
| 3 | Any abnormality of movement of the joints | | | |
| 4 | Any evidence of abnormality of the nervous system | | | |
| 5 | Any evidence of psychiatric disorder | | | |
| 6 | Heart: Any evidence of abnormality of the cardio-vascular system | | | |
| 7 | Any defect of hearing | | | |
| 8 | Does the applicant show any evidence of being addicted to alcohol, or of drug use? | | | |
| 9 | Blood Pressure: Systolic | Diastolic | | |
| | Is the applicant's blood pressure reading normal, for his age range? | *Yes | No | |
| 10 | Additional Remarks by the Medical Examiner: | | | |
| | | | | |
| | | | | |

Section F: Details of Overall Results (To be completed by Medical Examiner only)

I certify that I have on this day examined the applicant named in Section A. He/ She has shown me his/her identity card/ work permit as proof of identification. The answers to the questions above are correct to the best of my knowledge. Based on my observations and the results of the various tests and examinations as set out in Section B - E, I find the applicant physically and mentally

*** FIT / UNFIT**

to hold a vocational licence to drive a Public Service Vehicle.

Additional Remarks: _____

| | |
|------------------------------------|--|
| Signature of Medical Examiner: | |
| Name of Medical Examiner : | |
| Qualification of Medical Examiner: | |
| Name of hospital / Clinic: | |
| Address of hospital / Clinic: | |
| Date: | |

Note: Vocational licence applicants/ holders may also submit this duly completed and certified medical examination report separately to the Traffic Police Department for the Class 3/3A/4/4A/5 Singapore Driving Licence medical examination requirements for drivers aged 65 and above, where required.

*Delete where applicable