Land Transport Authority

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MEDICAL EXAMINATION REPORT
(VOCATIONAL LICENCE APPLICATION / RENEWAL)

Section A: Particulars of Applicant (To be duly completed by 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

***Name of applicant: _____** ***NRIC No: _____**

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/her 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 (bus or taxi).
(If the applicant is not fit to drive a Public Service Vehicle but is fit to act as a **Bus Attendant** on a Public Service Vehicle, please indicate accordingly.)

Additional Remarks:

Signature of Medical Examiner:	
Name of Medical Examiner:	
Qualification of Medical Examiner:	
Name of Hospital / Clinic:	
Address of Hospital / Clinic:	
Date:	

*Delete where applicable