**Medical Certificate For Driving Licence**

**Certificate No.:** [Certificate Number]
**Date:** [Date]

**To Whom It May Concern,**

This is to certify that:

**Name of Applicant:** [Full Name]
**Date of Birth:** [Date of Birth]
**Address:** [Address]

has undergone a thorough medical examination by me on [Date of Examination], and I have assessed his/her health in accordance with the medical standards required for holding a driving license.

**Medical Assessment:**

* **Vision**: Meets required standards for driving. [Specify if glasses or contact lenses are needed.]
* **Hearing**: Adequate for driving.
* **Motor Functions**: Capable of operating a motor vehicle safely.
* **Mental Health**: Mentally fit for driving, with no significant conditions affecting driving abilities.
* **Other Relevant Conditions**: [Mention any other medical tests or observations relevant to driving.]

Based on the examination results, it is my professional opinion that the above-named individual is medically fit to operate a motor vehicle in accordance with the traffic laws and regulations.

**Physician's Details:**

* **Name:** [Physician’s Full Name]
* **Qualification:** [Physician's Qualification]
* **Registration No.:** [Physician’s Registration Number]
* **Address:** [Physician's Practice Address]
* **Contact Number:** [Physician's Contact Number]

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** [Date of Signing]

**Stamp of the Medical Institution/Physician's Practice Stam**