

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