MEDICAL CERTIFICATE

DATE:_____

DRIVER'S LICENSE APPLICANT :_____

This is to certify that the aboved-named applicant is:

1. Physical and mentally fit to drive

- ☐ YES
- ☐ NO
  - ☐ UPPER LIMBS - AMPUTATED ☐ LEFT OR ☐ RIGHT ARM WITH PROSTHESIS
  - ☐ LOWER LIMBS - AMPUTATED ☐ LEFT OR ☐ RIGHT LEG WITH PROSTHESIS
  - ☐ POST-POLIOMYELITIS - WITH ONE PARALYZED LEG EITHER ☐ LEFT OR ☐ RIGHT
  - ☐ PARAPLEGIC - PARALYZED FROM THE WAIST DOWN

2. Has Clear Eyesight

- ☐ YES
- ☐ NO
  - ☐ PARTIALLY BLIND
  - ☐ COLOR BLIND
  - ☐ NEEDS PROPER CORRECTIVE GLASSES

3. Has Clear Hearing

- ☐ YES
- ☐ NO
  - ☐ SPEECH / HEARING IMPAIRED
  - ☐ NEEDS HEARING DEVICE

OTHER FINDINGS(if necessary): _____

_____

_____

_____

PHYSICIAN'S SIGNATURE

NAME OF PHYSICIAN: _____

COMPLETE ADDRESS OF CLINIC: _____

PRC LICENSE NUMBER:_____ VALID UNTIL:_____

PTR NUMBER:_____ VALID UNTIL:_____

VALID ONLY FOR FIFTEEN (15) DAYS FROM THE DATE OF ISSUANCE