## Form B

Photo

## MEDICAL SCREENING FOR DRIVING LICENSING

Part I and II of this form to be completed by the applicant:

Part I: Personal Information											
Name				Nationality			Passport No/Identity Card No./Voter Card No.				
Date of Birth/Age				Sex: M F			Occupation				
Residential Address in Bhutan:  Contact Number:											
Part II: Medical History (To be declared and signed by the applicant)											
	Y E S	N O					Y E S	N O	If yes, give brief details		
Mental illness					2.		t				
Asthma/COPD					4.	Diabetes Mellitus					
					6.	_					
Heart Disease					8.	drugs or alcoho					
Hearing Impairment					10.	Visual problem					
Long-term medication					12.	Physical deformity					
Trauma/injury											
I declare that all the information given above is correct and true. I also understand that I may be liable for actions by the concerned authority for providing false or misleading information.  Signature/thumb impression of the applicant											
	me side of Birth/Age sidential Address in Bintact Number:  THE II: Medical Hi  Mental illness  Asthma/COPD  Hypertension  Heart Disease  Hearing Impairment  Long-term medication  Trauma/injury  eclare that all the inforproviding false or misemature/thumb impress	me  sidential Address in Bhutan.  ntact Number:  Tt II: Medical History  Y E S  Mental illness  Asthma/COPD  Hypertension  Heart Disease  Hearing Impairment  Long-term medication  Trauma/injury  eclare that all the informatio providing false or misleadin	me  sidential Address in Bhutan: ntact Number:  Int II: Medical History (7	te of Birth/Age  sidential Address in Bhutan:  ntact Number:  Tr II: Medical History (To be declared and signature)  Y E N E N If yes, give brief details S O  Heart Disease Hearing Impairment Long-term medication  Trauma/injury  celare that all the information given above is correct and traproviding false or misleading information.	me	me   Nationality    the of Birth/Age   Sex: M      sidential Address in Bhutan:  mact Number:    Y	te of Birth/Age  Sex: M F Sex: M Se	te of Birth/Age  Sex: M F Occupe  sidential Address in Bhutan:  Intact Number:  IT II: Medical History (To be declared and signed by the applicant)  Y E N If yes, give brief details S O S O S O S O S O O OCCUP.  Asthma/COPD 4. Diabetes Mellitus Hypertension 6. Vertigo Heart Disease 8. Addiction to drugs or alcohol drugs or alcohol Hearing Impairment 10. Visual problem  Long-term medication 12. Physical deformity  Trauma/injury 12. Physical deformity  calare that all the information given above is correct and true. I also understand that I may be liable for providing false or misleading information.	te of Birth/Age  Sex: M F Occupation  sidential Address in Bhutan:  ntact Number:  ITH II: Medical History (To be declared and signed by the applicant)  Y E N If yes, give brief details S O Mental illness  Asthma/COPD  4. Diabetes Mellitus Hypertension Heart Disease Hearing Impairment Long-term medication Trauma/injury  Long-term medication  Long-term medication  Trauma/injury  Long-term medication  Trauma/injury		

Note: The applicant should inform the licensing authority if he/she develops medical condition that might interfere with driving ability.

Part III: Physical Examination: (to be completed by a registered medical or health person only)

A. Gene	ral	Normal	Abnormal	Brief details (if Abnormal)					
1.	Pulse rate Per min								
2.	Blood pressure/ mm Hg								
3.	Conjunctiva (Circle) Pallor/non-icteric/others								
	(specify)								
4.	Lymphadenopathy								
5.	Pedal oedema								
6.	Visible deformity								
B. Syste									
7.	Neurological status (sensory and coordination)								
8.	Cardiovascular system								
9.	Respiratory system								
10.	Per abdomen-								
	General								
	Liver								
11	Spleen								
11. 12.	Stigmata for alcohol and drug abuse  Visual acuity RE LE								
12.	Unaided LE								
	Pinhole								
	Corrected								
	Near vision								
	Colour vision								
	Visual field								
	Horizontal Vertical								
13.	Blood group								
Part IV: Certification and declaration									
I certify that the	person is: (check only one option)								
Fit for driving									
Fit for conditional driving, specify									
Unfit for driving									
Name and signature of the examining medical or health person  BMHC registration No. and Address:									
Name and signate	ure of the examining medical or health person	BMHC regi	stration No. and	Address:					

## Person shall be certified unfit for driving if the person has:

- 1. Best corrected vision in both eyes worse than 6/12 (Private driving purpose)
- 2. Best corrected vision in both eyes worse than 6/9 (Professional driving purpose)
- 3. Best corrected vision worse than 6/12 and better than 6/60 (Restricted driving license)
- 4. Colour blindness
- 5. Visual field less than 120 horizontal and 20 vertical
- 6. Deafness(Severe)(Professional driving purpose)
- 7. Uncontrolled epilepsy (more than 3 episodes of seizures in the last 6 months)
- 8. Uncontrolled diabetes mellitus
- 9. Recurrent or disabling vertigo
- 10. Sever withdrawal syndrome
- 11. Major Mental disorders (severe depression, psychosis, manic episode in bipolar disorder, severe anxiety, attention deficit hyperactivity disorder, etc.)