

## Self-Declaration Medical form

<b>Name:</b>	<b>Date of Birth:</b>
<b>Staff no.:</b>	<b>Job title:</b>
<b>Age:</b>	<b>Gender: Male <input type="checkbox"/> Female <input type="checkbox"/></b>
<b>City:</b>	<b>Do you wear glasses or contacts: Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>Company:</b>	<b>Mobile phone:</b>

**Conditions:**

Sr. No	Type	Yes	No	Sr. No	Type	Yes	No
1.	Diabetes Level-1 <input type="checkbox"/> Level-2 <input type="checkbox"/>			8.	Seizures, Fits, Convulsions, Epilepsy		
2.	Locomotive joint or limb problems			9.	Serious injuries (ex. Head or spinal injuries)		
3.	Strokes			10.	Eyesight problems/Visual disturbances (cataracts, double vision, night blindness, glaucoma)		
4.	Nervous or mental disorders			11.	Cerebral vascular accidents or disease		
5.	Heart trouble or angina			12.	Cognitive impairment		
6.	Alcohol or drug misuse or dependency			13.	Hearing problems		
7.	Any long terms medications			14.	Any other conditions that may affect your driving safely.		

**Additional Information (If any):**

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This is to certify that the above details are true and accurate.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_