Medical certificate *(Please send to doctor for completion)*
醫生證明 *(請交由醫生填寫)*
Supplementary Health Information Sheet for Driver Assessment
駕駛評估補充健康資料表格

Please complete the form by screening the medical history and the updated medical condition of the client for proceeding further driver assessments.

Name of client: _____ **HKID No.: _____**

Diagnosis: _____

Medical History: _____
_____
_____

Please tick the box and provide details on whether the client is currently suffering from any of the following diseases or physical disabilities as specified in the First Schedule of Road Traffic (Driving Licences) Regulations (Chapter 374B)

	No	*Yes*	
1. Epilepsy.	☐	☐	*Details:* _____
2. Liability to sudden attacks of disabling giddiness or fainting due to hypertension or any other cause.	☐	☐	*Details:* _____
3. Mental disorder for which the applicant for the licence, or, as the case may be, the holder of the licence is liable to be detained under the Mental Health Ordinance (Cap. 136) or is receiving treatment as an in-patient in a mental hospital within the meaning of that Ordinance.	☐	☐	*Details:* _____
4. Any condition causing muscular incoordination.	☐	☐	*Details:* _____
5. Uncontrolled diabetes mellitus.	☐	☐	*Details:* _____
6. Inability to read at a distance of 23 metres in good daylight (with the aid of spectacles or other corrective lenses, if worn) a registration mark.	☐	☐	*Details:* _____
7. Any other disease or disability which is likely to render him/ her incapable of effectively driving and controlling a motor vehicle or suitably adapted motor vehicle to which such licence refers without endangering public safety, provided that deafness shall not of itself be deemed to be any such disability.	☐	☐	*Details:* _____

According to the Road Traffic (Driving Licences) Regulations (Chapter 374B), if a person is suffering from any of the diseases or physical disabilities as specified in the First Schedule, the Commissioner for Transport shall refuse his application for driving licence or cancel his driving licence.

Name of Doctor: _____ Signature of Doctor: _____

Date of Examination: _____ Hospital/Clinic Stamp: _____

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