CENTRAL MOTOR VEHICLES RULES, 1989

MINISTRY OF ROAD TRANSPORT & HIGHWAYS • GOVERNMENT OF INDIA

FORM 1-A

[See Rule 5(1), (3), (7), 10(a), 11(1)]

MEDICAL CERTIFICATE (MBBS DOCTOR)

(Execution Requirement: 1 Copy)

To,
The Registering / Licensing Authority,
Regional Transport Office, _____

1. Full Name of Applicant / Owner: _____
2. Son / Daughter / Wife / Care of: _____
3. Permanent Address: _____
4. Present / Business Address: _____
5. Registration Number of Vehicle: _____ (if applicable)
6. Class & Type of Vehicle: _____ Make / Model: _____
7. Chassis Number (VIN): _____ Engine Number: _____
8. Visual Acuity (Right Eye / Left Eye): Uncorrected: _____/_____ • Corrected: _____/_____
9. Red-Green Color Vision Defect: Present [ ] Absent [ ] (Ishihara Test)
10. Night Blindness / Epilepsy History: No [ ] Yes [ ]
11. Examining Doctor NMC / Council Reg No: Reg No: _____ State: _____

I/We hereby declare that the particulars furnished above are true and complete to the best of my/our knowledge and belief. I/We undertake to abide by the provisions of the Motor Vehicles Act, 1988 and the Central Motor Vehicles Rules, 1989.

Date: _____ / _____ / 202___
Place: _____

_____
Signature / Thumb Impression of Applicant / Owner

_____
Signature & Seal of Registered Medical Practitioner
NMC / State Council Reg No: _____

Clinic / Hospital Seal: [ ]

FOR OFFICIAL USE OF THE REGISTERING / LICENSING AUTHORITY ONLY

Application Ref No: _____ • Verified & Inspected on: _____/_____/202___
The application is hereby **[ ] GRANTED** **[ ] REFUSED** under the provisions of CMVR Rule 5(1), (3), (7), 10(a), 11(1).
Reason for Refusal (if applicable): _____

Office Seal • Date: _____/_____/202___ Signature & Designation of Inspecting Officer