

# COLOR DEFECIENCY TEST REPORT

I, the undersigned below, declare that :

Name : \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Gender : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

Selection Number : \_\_\_\_\_

has been examined for colour blindness condition and the results are :

1. Color Vision Examination :

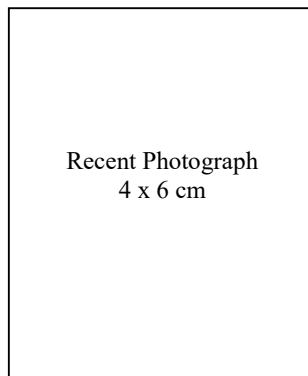
No Color Blindness Condition

Partial Color Blindness

Total Color Blindness

2. Note : \_\_\_\_\_

\_\_\_\_\_



....., ..... 20.....

*Signature of Ophthalmologist*

(.....)

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*Note : the signature and/or official stamp shall touch the photograph*