



# COLOR DEFECIENCY TEST REPORT

I, the undersigned below, declare that :

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

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

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

\_\_\_\_\_

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

1. Color Vision Examination :

No Color Blindness Condition

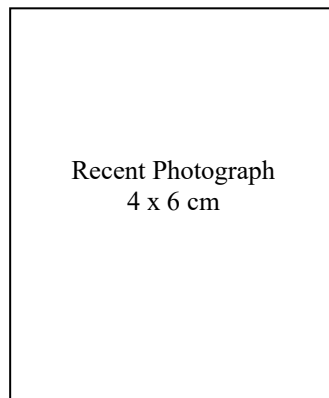
Partial Color Blindness

Total Color Blindness

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

\_\_\_\_\_

\_\_\_\_\_



....., .....

*Signature of Ophthalmologist*

(.....)

.....

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