Clear Form

SECTION 3: General Questions for Driver/Applicant

1. How many traffic accidents have you been involved in while driving in the past 5 years? _____ ☐ None
2. Were you injured in any traffic accidents? ☐ Yes ☐ No

   If yes, please describe your injuries: _____

   Was treatment given? ☐ Yes ☐ No If yes, where was treatment given? _____
3. Describe any loss of consciousness or any impairment of consciousness in the past 5 years: _____

   _____ ☐ None

   Did you tell your doctor about the event(s)? ☐ Yes ☐ No

   If yes, what was the diagnosis for the event(s)? _____
4. Have you ever become lost when driving in familiar areas? ☐ Yes ☐ No
5. Has any family member or friend made a suggestion that you not drive or limit your driving? ☐ Yes ☐ No
6. Have you ever been told by a doctor to limit or stop driving? ☐ Yes ☐ No
7. How many times in the past 5 years have you had contact with police as a result of a traffic stop or accident?

   _____ ☐ None
8. Do you require a passenger to assist you when driving? ☐ Yes ☐ No
9. Please list all medications you are currently prescribed and/or taking: _____

   _____
10. How many alcoholic drinks do you consume per day? _____ Per week? _____ Per month? _____
11. Have you had treatment or a recommendation for treatment for any of the following? :

    Alcohol Use ☐ Yes ☐ No Illicit Drug Use ☐ Yes ☐ No Prescription Drug Use ☐ Yes ☐ No
12. Do you wear or use any of the following corrective lenses? Check all that apply:

    ☐ Glasses ☐ Contacts ☐ Telescopic Lens Device ☐ Other: _____
13. Do you have any progressive or degenerative diseases of the eye? Check all that apply: ☐ Retinitis Pigmentosis

    ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Other: _____
14. How often do you drive at night? ☐ Regularly ☐ Sometimes ☐ Never
15. How often do you drive on the freeway? ☐ Regularly ☐ Sometimes ☐ Never
16. How many miles do you drive per day? _____ Per week? _____ Per month? _____
17. How often do you wear your seatbelt? ☐ Always ☐ Sometimes ☐ Never

SECTION 4: Driver/Applicant Certification

I hereby authorize the release of information to the Department of State only for the purpose of assisting in evaluating my ability to safely operate a motor vehicle. I am aware that the Department of State may contact my physician for clarification or follow-up. I certify that my responses contained in this document are true and accurate to the best of my knowledge and belief.

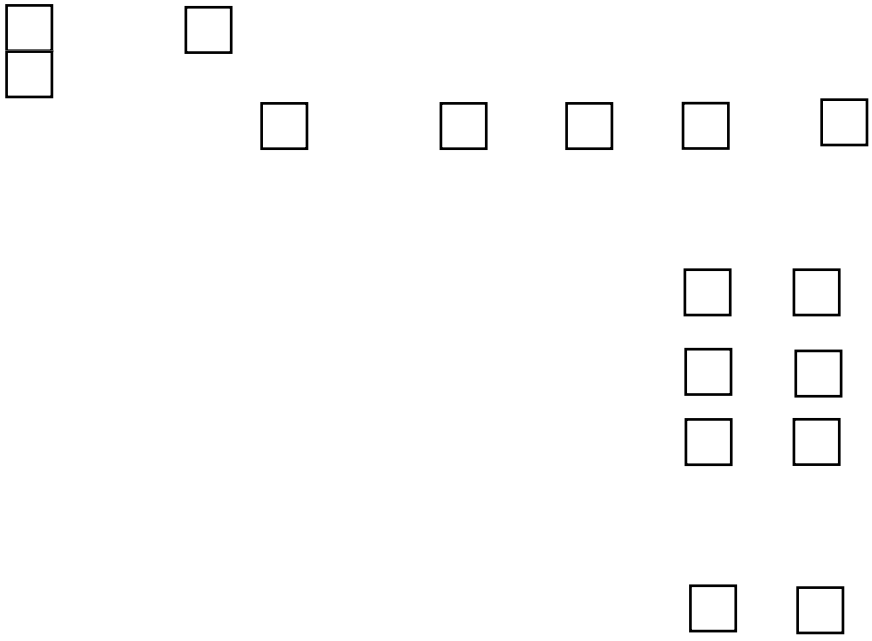
Driver/Applicant's Signature: _____

If you assisted the driver/applicant with the completion of this form, please complete the following information.

Name	Telephone Number	Relationship to Driver/Applicant	
Address	City	State	Zip

I am completing Sections 1 through 4 of this form at the request of the driver/applicant.

Signature: _____ Date: _____



TERTIARY DIAGNOSIS (Third most likely to impair driving)

Diagnosis:	The patient's condition is (check all that apply):	Prescribed Medication	Dosage	Start Date
Symptoms:	☐ Episodic ☐ Chronic			
Age at onset:	☐ Progressive			

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Supporting facts for prognosis:

Treatment or therapy plan:

Does the patient report the condition is adequately controlled with medication, treatment or therapy? ☐ Yes ☐ No ☐ N/A
Comments:

Is another medical specialist involved in treatment of this condition? ☐ Yes ☐ No
If yes, name and specialty:

Has the patient reported a loss of, or impairment of consciousness? ☐ Yes ☐ No
If yes, please describe:

Date of last episode: Frequency:

If the patient experienced an episode or medical event, is there reasonable medical evidence it was due to a medically supervised change in medication or dosage? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

Comments:

SECTION 7: Physician's Certification

Name (First, Middle, Last)	M.D. or D.O.	Professional License Number	
Address	City	State	ZIP
Telephone Number	Type of Practice or Medical Specialty		

As of this date, I certify that I have reviewed Sections 1 through 4 and completed Sections 5 through 7 and that this Physician's Statement of Examination is true to the best of my knowledge and belief based on information obtained from the patient, the patient's known medical history, and a patient examination. I understand that the decision to grant, suspend, or reinstate an individual's driving privileges rests solely with the Department of State, which may consider other facts or conditions when making this decision.

Physician's Signature: _____ **Date:** _____
(Required)

Sign below if this form was completed by a psychologist, physician's assistant, or nurse practitioner.

PSY/PA/NP Signature: _____ Date: _____

For Driver Assessment Use Only

☐ FAVORABLE _____ ☐ COME-UP DATE _____
☐ RESTRICTION _____
☐ MUST PASS _____
☐ UNFAVORABLE _____
☐ QUESTIONABLE _____
☐ REFER FOR REEXAMINATION _____
☐ NEED ADDITIONAL INFORMATION _____
☐ MEDICAL ☐ VISION ☐ SKILLS TESTING ☐ SUBSTANCE USE DISORDERS EVALUATION

REVIEWED BY: _____ DATE: _____