



Physician's Opinion Statement – Driver Fitness

On _____ I examined _____ date of birth _____

to determine his or her mental and physical fitness to operate a motor vehicle. My findings are as follows:

General Health

- 1. Is there any nervous, organic, or functional disease which has advanced, or is likely to advance during the next 12 months, to a degree that will interfere with safe driving? Yes No
- 2. Has the applicant ever been treated or received medication for any nervous disorders (muscular dystrophy, multiple sclerosis, cerebral palsy)? Yes No
- 3. Has the applicant ever been treated for epilepsy? Yes No

Mental Condition

- 4. Has a loss of alertness or mental activity adversely affected the applicant's ability to handle emergencies frequently encountered in driving? Yes No

Physical Condition

- 5. Has the applicant lost any of the following members? Yes No
 - Finger Hand Arm Leg
- a. Is there any partial or total loss of use of any of the above that impairs safe driving ability? Yes No
- b. Is there any other bodily defect or limitation that is likely to hinder safe driving? Yes No
- c. Does the car have special controls? Yes No

Hearing

- 6. Does the applicant need a hearing aid to hear ordinary conversation? Yes No

Vision

- 7. Has the applicant ever had cataracts? Yes No
- 8. Has the applicant lost the use of either eye? Yes No
- 9. Is there any opacity of the crystalline lenses of either or both eyes? Yes No
- 10. Visual acuity with corrective lenses
Both Eyes if same: 20/ _____ Left Eye: 20/ _____ Right Eye: 20/ _____
- 11. Do the above visual acuity ratings suggest an inability to safely operate a motor vehicle? Yes No
- 12. Please explain any "Yes" answers above:

I have examined the above-named person and attest that these responses are true. In my professional opinion, the above-named person is in adequate health for the safe operation of a motor vehicle.

Name of Examining Physician	Signature of Examining Physician	Phone Number	Date
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