West Virginia Department of Transportation

Division of Motor Vehicles
Medical Report Form

PART I • TO BE COMPLETED BY THE DRIVER *(You must complete Part I before presenting the medical form to your doctor.)*

A.) Patient Authorization

This medical report must reflect the results of the licensed physician's personal examination of the patient performed within 90 days of this report being filed. It must be signed by the patient authorizing the physician to release this report and any attachments to DMV.

I hereby authorize the licensed physician completing and signing this medical report to release such report to DMV along with any other medical information necessary to determine my fitness to operate a motor vehicle safely.	PATIENT'S SIGNATURE **(X)** DATE	DRIVER'S LICENSE NUMBER

PATIENT'S NAME (Please Print) (Last) (First) (Initial) | DATE OF BIRTH | DAYTIME TELEPHONE NUMBER ( )

PATIENT'S ADDRESS (Street) (City) (State) (Zip Code)

EMAIL ADDRESS (Optional)

PART II • TO BE COMPLETED BY THE EXAMINING PHYSICIAN

B.) Applicant's Medical History • This form must be signed by a licensed medical practitioner.

1. How long has applicant been your patient? _____

Date you last treated applicant before today: ___/___/___

2. Names of other physicians who have treated applicant in the past two years: _____

_____

_____

Has the applicant ever had any of the following illnesses or conditions? If YES, you must complete the appropriate sections under PART III.

- ☐ *Yes* ☐ *No* ***DIABETES MELLITUS***
- ☐ *Yes* ☐ *No* ***MUSCULOSKELETAL DISORDER***
- ☐ *Yes* ☐ *No* ***EMOTIONAL OR MENTAL ILLNESS***
- ☐ *Yes* ☐ *No* ***CARDIOVASCULAR DISORDER***
- ☐ *Yes* ☐ *No* ***ALCOHOL/DRUG PROBLEM***
- ☐ *Yes* ☐ *No* ***NEUROLOGICAL DISORDER***
- ☐ *Yes* ☐ *No* ***SLEEPING DISORDER***

PART III • TO BE COMPLETED BY THE EXAMINING PHYSICIAN

C.) Details on Applicant's Conditions or Illnesses • ONLY complete sections for questions answered with a YES under Section II.

A. DIABETES MELLITUS: | *THIS SECTION MUST BE COMPLETED BY A BOARD CERTIFIED/ELIGIBLE ENDOCRINOLOGIST*

1. Age of onset: _____ **Does applicant take insulin or oral diabetic medication?** ☐ *Yes* ☐ *No* If yes what kind and dosage?

_____

2. Has applicant ever been in diabetic coma or shock? ☐ *Yes* ☐ *No* If yes, how many times? _____

Date of last coma/shock: ___/___/___

3. Has the applicant had insulin reactions severe enough to impair judgment or ability to drive a motor vehicle? ☐ *Yes* ☐ *No*

If yes, how many times? _____ Date of last episode: ___/___/___ **Explanation:** _____

_____

4. Does applicant have diabetic retinopathy? ☐ *Yes* ☐ *No* **5. Is applicant's diabetic condition under adequate control?** ☐ *Yes* ☐ *No*

B. MUSCULOSKELETAL DISORDER: *(Patient may be required to pass a Skilled Performance Evaluation (SPE))*

1. What type of musculoskeletal disorder does applicant have? _____

2. Are there any spastic or paralyzed muscles? ☐ *Yes* ☐ *No* If yes, briefly describe: _____

3. Has there been an amputation? ☐ *Yes* ☐ *No* If yes, what portion of the anatomy? _____

4. Does applicant require any orthopedic appliance or supports? ☐ *Yes* ☐ *No* If yes, what? _____

C. EMOTIONAL OR MENTAL ILLNESS:

1. Has the applicant been treated/hospitalized for an emotional or mental illness? ☐ *Yes* ☐ *No*

If yes, when? ___/___/___ Diagnosis: _____

Condition on discharge: _____

2. Present medication (type and dosage): _____

_____ Does medication affect mental alertness? ☐ *Yes* ☐ *No*

3. Does the applicant now show evidence of, or in the past year had difficulty with any emotional or mental illness such as extreme anxiety, depression, paranoia, confusion, delusions, or hallucinations ☐ *Yes* ☐ *No*

If yes, briefly explain: _____

4. Does applicant exhibit homicidal, suicidal, or destructive behavior? ☐ *Yes* ☐ *No*

If yes, when? ___/___/___ Diagnosis: _____

D. CARDIOVASCULAR DISORDER:

1. What type of cardiovascular disease does applicant have? _____

_____

2. Functional capacity (AHA), Check one of the following:

☐ ***Class I*** *- No limitation of physical activity; ordinary physical activities cause no undue dyspnea, anginal pain or palpitation.*

☐ ***Class II*** *- Slight limitation of physical activity; comfortable at rest and with mild exertion.*

☐ ***Class III*** *- Marked limitation of physical activity; comfortable at rest but symptoms occur with mild activity.*

☐ ***Class IV*** *- Complete limitation of physical activity; symptoms occur at rest.*

3. Does applicant have congestive heart failure? ☐ *Yes* ☐ *No* If yes, is it adequately controlled? ☐ *Yes* ☐ *No*

4. Does applicant have history of arrhythmia? ☐ *Yes* ☐ *No* If yes, state type and how it's controlled: _____

_____

5. If applicant has hypertension, answer the following:

A. What is present BP reading? _____

B. Is there any indication of abnormal urinary function, hypertensive cerebrovascular damage, left ventricular hypertrophy, peripheral vascular disease, arterial-venous malformation, or any hypertensive abnormality? ☐ *Yes* ☐ *No*

If yes, please specify: _____

_____

6. Is there any current clinical diagnosis or myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure? ☐ *Yes* ☐ *No* If yes, please describe: _____

_____ Date of last episode: ___/___/___

7. Does applicant take medication regularly for a cardiovascular condition? ☐ *Yes* ☐ *No*

If yes, state type and dosage? _____

_____

_____

E. ALCOHOL/DRUG PROBLEMS:

1. Is there any evidence or personal knowledge of addiction, habituation, or abuse of alcohol or other drugs? ☐ *Yes* ☐ *No*

If yes, what and how much? _____

2. Has applicant been treated for alcoholism or drug dependency? ☐ *Yes* ☐ *No* If yes, when? ___/___/___

Where? _____

3. Does the patient drink alcoholic beverages now? ☐ *Yes* ☐ *No* If yes, to what extent? _____

4. If applicable; how long has patient been free of abuse of alcohol or other drugs? _____

F. NEUROLOGICAL DISORDER:

1. Does the applicant have epilepsy or convulsive seizures? ☐ *Yes* ☐ *No* If yes, provide details below:

A. Date of onset: ___/___/___ Date of last seizure: ___/___/___ Brief description of seizures: _____

_____

_____

B. How often do they occur? _____

C. Do these seizures occur only during sleep (nocturnal epilepsy)? ☐ *Yes* ☐ *No*

D. Does applicant take medications for seizure control ? ☐ *Yes* ☐ *No* If yes, provide details below:

When was present regimen of therapy initiated? ___/___/___ Please list medications and recent blood levels below:

Medication: _____ Blood Level: _____ Date: ___/___/___

Medication: _____ Blood Level: _____ Date: ___/___/___

E. Date of last EEG: ___/___/___ Interpretation: _____

2. Has applicant experienced loss of consciousness, blackout, fainting or disorientation in the past year? ☐ *Yes* ☐ *No*

If yes, how often? _____

3. Has the applicant had "blackout" spells or fainting spells unrelated to epilepsy or diabetes? ☐ *Yes* ☐ *No*

If yes, specify cause if known: _____

Date of last episode: ___/___/___

4. Has the applicant suffered brain damage? ☐ *Yes* ☐ *No* If yes, describe briefly: _____

5. Does applicant show deficiency in mentation? ☐ *Yes* ☐ *No*

6. Does applicant suffer from poor coordination? ☐ *Yes* ☐ *No*

If yes, state cause: _____

G. SLEEP DISORDER:

1. Does the applicant suffer from any sleep disorder? ☐ *Yes* ☐ *No*

If yes, please indicate what type: _____

2. Is applicant currently being treated? ☐ *Yes* ☐ *No*

3. Is disorder currently under control? ☐ *Yes* ☐ *No*

4. Will this affect applicant's ability to drive a commercial vehicle? ☐ *Yes* ☐ *No*

PART III • TO BE COMPLETED BY THE EXAMINING PHYSICIAN (CONTINUED)

PART IV • TO BE COMPLETED BY THE EXAMINING PHYSICIAN

D.) Examining Physician's Comments, Recommendations, and Certification

1. In your professional opinion, can the applicant safely operate a commercial vehicle? ☐ *Yes* ☐ *No*

2. Do you recommend periodic medical evaluations for driver license purposes? ☐ *Yes* ☐ *No*

If yes, how often? _____

3. Do you feel there should be limitations on the size or type of commercial vehicle to be operated? ☐ *Yes* ☐ *No*

If yes, specify: _____

_____

4. In your opinion, should there be any restrictions imposed such as: limitation of driving distance, daylight driving only, or no interstate driving? ☐ *Yes* ☐ *No* If yes, specify: _____

_____

_____

_____

5. Are there any other medical conditions not shown on this report which may affect the applicant's safe operation of a commercial vehicle? ☐ *Yes* ☐ *No* If yes, specify: _____

_____

_____

Physician's Name (Please print in ink or type)	Medical License Number	State Of Issue	
Business Address	City	State	Zip
Signature **(X)**	Date / /	Telephone Number ( ) -	