DLAB-1
REV 2/12

West Virginia Department of Transportation

Division of Motor Vehicles

Medical Report Form

WV DMV Medical Review Services
PO Box 17030 • Charleston, WV 25317
Phone: (304) 926-3961 Fax: (304)957-0323

FILE NUMBER:
(DMV USE ONLY)

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

A.) Patient Authorization

The patient named below has been referred to the DMV Driver Services Division concerning their ability to operate a motor vehicle safely. 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	LICENSE NUMBER

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

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

PART II • TO BE COMPLETED BY THE EXAMINING PHYSICIAN *(When the form is complete mail or fax it to WV DMV.)*

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***

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:

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? ☐ *Yes* ☐ *No* If yes, how many times? _____ Date of last coma: ___/___/___

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

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

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

B. MUSCULOSKELETAL DISORDER:

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 for an emotional or mental illness? ☐ *Yes* ☐ *No* If yes, describe briefly: _____

_____

2. Present medication (type and dosage): _____

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

3. Does applicant demonstrate any mental retardation? ☐ *Yes* ☐ *No* If yes, describe briefly: _____

_____

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. Have there been syncopal episodes due to cardiovascular disease? ☐ *Yes* ☐ *No* 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. Has applicant been treated for alcoholism or drug dependency? ☐ *Yes* ☐ *No* If yes, when? ___/___/___

Where? _____

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

PLEASE INSERT PATIENTS NAME AND DATE OF BIRTH BELOW.

PATIENT'S NAME (Please Print) (Last)	(First)	(Initial)	DATE OF BIRTH

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

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 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: ___/___/___

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

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

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

If yes, state cause: _____

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 motor vehicle? ☐ *Yes* ☐ *No*

2. Do you recommend periodic medical evaluations for driver license purposes? ☐ *Yes* ☐ *No* **If yes, how often?** _____

3. 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: _____

_____

_____

_____

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 ( ) -	

PLEASE INSERT PATIENTS NAME AND DATE OF BIRTH BELOW.

PATIENT'S NAME (Please Print) (Last)	(First)	(Initial)	DATE OF BIRTH