



Department of Public Safety  
**Oklahoma Driver License  
Medical Advisory Committee**

Dear Doctor:

The bearer of this medical examination form has been requested to undergo a medical examination by a licensed physician or appropriate medical professional. **The completion of this form must be based on an examination performed within the last 60 days.**

**The applicant will be responsible for any professional fee charge for the examination.**

This medical examination is required under one or more of the following categories:

- (1) All original applicants who have known medical conditions which may affect their driving ability.
- (2) Any driver who indicates to an investigating officer at the scene of an accident that he/she did not know the cause of the accident because of a blackout or seizure.
- (3) All licensed drivers who have proven accident records or possible physical impairments which may affect their driving ability.
- (4) Any person reported by a verifiable source as having questionable physical or mental capacities to properly operate a motor vehicle with due care.

Our efforts must be for the greatest protection available to the general public. We appreciate your interest and assistance in the program.

Sincerely,

Medical Advisory Committee



Department of Public Safety

## Authorization Agreement

This medical examination authorization agreement must be completed by the applicant and signed in the presence of the examining physician.

I hereby authorize the physician(s) listed, who may have attended me, and/or the hospital(s) and/or clinic(s) listed below, in which I may have been treated, to give the Department of Public Safety any information they may request concerning my condition.

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Hospital or clinic

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Hospital or clinic

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Hospital or clinic

I understand that this authorization includes permission for the Department of Public Safety to have this information reviewed by the Oklahoma Driver License Medical Advisory Committee. The Committee will provide to DPS a medical opinion based on my case which will serve as a guide in determining my medical capabilities to operate a motor vehicle safely, in the interest of the general public.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of licensee/applicant



DPS USE ONLY

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

Address: \_\_\_\_\_ DL No: \_\_\_\_\_

Physical description:

Height \_\_\_\_\_ Weight \_\_\_\_\_

1. Orthopedic and neuromuscular

- Yes \_\_\_ No \_\_\_ A. Spastic or ankylose joints?
Yes \_\_\_ No \_\_\_ B. Joint ataxia, paralysis or weakness.
Yes \_\_\_ No \_\_\_ C. Amputations?
If yes, type and date: \_\_\_\_\_
Yes \_\_\_ No \_\_\_ D. Prosthetic devices used?
Do these compensate for driving tasks?
Are additional prosthetic devices needed?
Yes \_\_\_ No \_\_\_ E. Other orthopedic deformities?
If yes, describe: \_\_\_\_\_

2. Cardio-Vascular BP \_\_\_\_\_ Pulse \_\_\_\_\_

Please check if any of the below conditions are present:

- \_\_\_ Stokes-Adams syndrome \_\_\_ Syncope
\_\_\_ Cardiac Decompensation \_\_\_ Vertigo
\_\_\_ Angina Pectoris \_\_\_ Arrhythmia
\_\_\_ Emphysema \_\_\_ Dyspnea
\_\_\_ Significant Arteriosclerosis \_\_\_ Edema

3. Diabetes

Is patient a known diabetic? Yes \_\_\_ No \_\_\_ If yes, give date of onset: \_\_\_\_\_
Status of control: \_\_\_\_\_
Insulin dependant: Yes \_\_\_ No \_\_\_ Other anti-diabetic drugs: Yes \_\_\_ No \_\_\_
Insulin reactions: Yes \_\_\_ No \_\_\_ Diabetic Acidosis: Yes \_\_\_ No \_\_\_
If reactions, give date of the latest reaction: \_\_\_\_\_
Did this reaction result in loss of consciousness or hospitalization? Yes \_\_\_ No \_\_\_
Daily insulin dosage: \_\_\_\_\_

4. Hypoglycemia

Is the patient hypoglycemic? Yes \_\_\_ No \_\_\_ Date of onset: \_\_\_\_\_
Status of control: \_\_\_\_\_
Has patient had a lapse, loss or alteration of consciousness as a result? Yes \_\_\_ No \_\_\_
If yes, give date & description: \_\_\_\_\_

## 5. Vision

ACUITY	Right eye	Left eye	Both eyes
Without lenses	20/	20/	20/
With present lenses	20/	20/	20/
With best correction	20/	20/	20/
Ocular pathology: _____			
How often would you recommend re-examination for driving purposes? _____			
<b>FIELD OF VISION (in degrees)</b>			
Right eye: Temporal _____ Nasal _____      Left eye: Temporal _____ Nasal _____			
If disease or injury is present, give the diagnosis: _____			
Would you recommend any restrictions be placed on this person's driver license, such as locale, max speed, daylight only, etc?      No ( )      Yes ( )      If yes, please explain: _____			
_____ Date of examination		_____ Name of Ophthalmologist or Optometrist/treating physician (print)	
_____ License no./State of issue	_____ Mailing address	_____ Signature	

## 6. Drugs and Alcohol

Yes \_\_\_ No \_\_\_      Is there any evidence or personal knowledge of substance abuse or addiction to drugs or alcohol? If yes, give a brief history of substance usage and if treatment is recommended or completed.

## 7. Psychological / Cognitive / Dementia / Alzheimer's Assessment

Yes \_\_\_ No \_\_\_      Does this person have a diagnosed mental disorder or is there any evidence of tension, tremulousness, anxiety, depressions, hostility, bizarre behavior, paranoia, suicidal tendencies, impairment of judgement, confusion, mental retardation, hallucinations, or delusions? If yes, explain: \_\_\_\_\_

Yes \_\_\_ No \_\_\_      Do you suggest further psychiatric examination?

## 8. Syncope (if applicable)

Give date of most recent lapse, loss or alteration of consciousness: \_\_\_\_\_

Provide cause or diagnosis: \_\_\_\_\_

Prognosis \_\_\_\_\_

**9. Epilepsy/Seizure disorder**

Yes\_\_\_ No\_\_\_ Do you know or suspect this patient has a seizure disorder?

Type of seizures: \_\_\_\_\_

Date of onset: \_\_\_\_\_

Number of episodes *within the last six months*: \_\_\_\_\_

Date, description and cause (if known) of last episode resulting in lapse, loss or alteration of consciousness: \_\_\_\_\_  
\_\_\_\_\_

Yes\_\_\_ No\_\_\_ Is this person currently being treated by a neurologist? (If yes, additional information from the neurologist may be requested).

If no longer on anti-convulsant medication, when was it discontinued? \_\_\_\_\_

**10. Other Neurological disorder**

Yes\_\_\_ No\_\_\_ Does this person have a limiting or progressive neurological deficit?

Diagnosis: \_\_\_\_\_

Description of limitation: \_\_\_\_\_

How would the condition affect his/her ability to control a motor vehicle? \_\_\_\_\_  
\_\_\_\_\_

Yes\_\_\_ No\_\_\_ Is the condition progressive?

**11. Other Conditions**

List any other significant disease, ailment or complication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**12. List the medications and dosage which patient is taking**

Name of Drug

Prescribed Dosage

_____	_____
_____	_____
_____	_____
_____	_____

**13. How long have you been treating this patient?**

Yes\_\_\_ No\_\_\_ Has patient been reliable in taking necessary medications and reporting for scheduled appointments?

**14. In your medical judgment, is the condition of the patient controlled?**

Yes \_\_\_ Length of current stable period: \_\_\_\_\_

No \_\_\_ Please explain: \_\_\_\_\_

\_\_\_\_\_

**15. Would you recommend that the Department retest this person's driving ability?**

Yes\_\_\_ No\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_

**16. In your professional opinion, from a medical standpoint, is this person physically and mentally capable of operating a motor vehicle safely?**

Yes\_\_\_ No\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_

**DATE OF THIS EXAMINATION:** \_\_\_\_\_

**MAB USE ONLY**

\_\_\_\_\_  
Print Name of Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
License No. and State

\_\_\_\_\_  
Specialty

**PHYSICIAN:**

**PLEASE MAIL FORMS TO:**

Department of Public Safety  
Medical Advisory Board  
PO Box 11415  
Oklahoma City, OK 73136-0415

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip

\_\_\_\_\_  
Telephone