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
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
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?
   Yes___ No___  Do these compensate for driving tasks?
   Yes___ No___  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

<table>
<thead>
<tr>
<th>ACUITY</th>
<th>Right eye</th>
<th>Left eye</th>
<th>Both eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without lenses</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
</tr>
<tr>
<td>With present lenses</td>
<td>20/</td>
<td>20/</td>
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</tr>
<tr>
<td>With best correction</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
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</tbody>
</table>

Ocular pathology: ________________________________________________________________

How often would you recommend re-examination for driving purposes? ___________________________

FIELD OF VISION (in degrees)

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

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Prescribed Dosage</th>
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<tbody>
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</tbody>
</table>
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

Telephone
________________________