



Department of Public Safety
DRIVER COMPLIANCE DIVISION
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 sixty (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 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 deeply appreciate your interest and assistance in the program.

Sincerely yours,

MEDICAL ADVISORY COMMITTEE

AUTHORIZATION AGREEMENT

This medical examination authorization agreement must be completed and signed by the applicant in order for the Department of Public Safety to review the information for driver license purposes.

* * * * *

I hereby authorize the following physician(s) who may have attended me and/or the hospital(s) or clinic(s) 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

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PHYSICIAN

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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 for the purpose of giving the Department a medical opinion on my case for guidance in determining my physical or mental capabilities to operate a motor vehicle safely, in the interest of the general public.

DATE

SIGNATURE OF
LICENSEE/APPLICANT

PRINT NAME IN FULL: _____

MAILING ADDRESS _____

DOB _____

CITY, ST, ZIP: _____

DL#: _____

NEUROLOGICAL EXAMINATION
(To be completed by a Neurologist or the treating Physician)

1. Patient history of lapse, loss or alteration of consciousness level, or other event resulting in loss of muscular control:

A) Type of episode(s) the patient has experienced (grand mal, partial, nocturnal, etc):

(1) Primary: _____

(2) Secondary: _____

(3) Other: _____

B) Description of episode(s): _____

C) Approximate age at onset: _____ Did initial episode result in LOC? Yes No

D) Is there any regularity about their occurrence? Yes No If yes, please explain:

2. Results of EEG (If available):

3. Anti-convulsant medication prescribed (name and dosage):

If no longer on anti-convulsant medication, date it was discontinued: _____

4. What is your assessment of this patient's current status? (Check those applicable)

A) Completely controlled _____ C) Occasional seizure asleep _____

B) Occasional seizure awake _____ D) Uncontrolled _____

