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                           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 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.

_________________________________  SIGNATURE OF
DATE                                 LICENSEE/APPLICANT
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 _____
5. **Number of episodes within the past six (6) months resulting in loss, lapse or alteration of consciousness:** __________ Date of last episode: ________________

Note: If the person has experienced any episode(s) involving loss, lapse or alteration of consciousness within the last six (6) months, please advise if you would consider the episode(s) to fit into either of the following categories; if so, **explain in Section 8 below**:
   A) The episode resulted from a deliberate change in medication ordered by the physician and control has again been established.
   B) The episode was an isolated occurrence and another episode is unlikely to occur with reasonable medical certainty.

6. **List any other significant ailments or conditions:**
   _____________________________________________________________________________________

7. **From a medical standpoint, do you feel this person is safe to drive a motor vehicle?**
   Yes   No   Comments or recommendations ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

8. **Remarks or points of clarification:**
   _____________________________________________________________________________________
   _____________________________________________________________________________________
   _____________________________________________________________________________________
   _____________________________________________________________________________________

**DATE OF THIS EXAMINATION** ______________

**ATTN PHYSICIAN**
Recee Mail forms direct to:
Exec Secy, Medical Advisory Committee
Department of Public Safety
PO Box 11415
Oklahoma City, OK 73136-0415

**SIGNATURE OF PHYSICIAN**

**PRINT NAME OF PHYSICIAN**

**SPECIALTY**

**LICENSE # AND STATE OF**

**MAILING ADDRESS**

**CITY, STATE AND ZIP**

(_____) ________________________________

**TELEPHONE**