

PHYSICAL EXAMINATION REPORT

For S or P Endorsement

Wisconsin Department of Transportation (WisDOT)

MV3030B 01/2023 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

Medical Review, PO Box 7918, Madison, WI 53707-7918

Telephone: (608) 266-2327 FAX: (608) 267-0518

Email: dmvmedical@dot.wi.gov



Incomplete forms will be returned for completion.

Applicant Name		Driver License Number [][][][][] - [][][][][] - [][][][][][] - [][][][][]				Birth Date [][] - [][] - [][][][][]			
Street Address		City		State		ZIP Code		(Area Code) Telephone Number	

Note: Pursuant to Trans 112, Wis. Admin. Rules (copy available upon request); this report is to be completed prior to consideration for licensing. The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver's licensing. Any charges or fees for the medical or vision examinations and the preparation or completion of this form are responsibility of the applicant (driver).

VISION SECTION - REQUIRED

Numerical readings must be provided.			YES	NO	
ACUITY	UNCORRECTED	CORRECTED	<input type="checkbox"/>	<input type="checkbox"/>	Is the temporal field of vision at least 70 degrees from center in each eye?
Right Eye	20/	20/	<input type="checkbox"/>	<input type="checkbox"/>	Can the applicant recognize and distinguish the colors red, amber, and green?
Left Eye	20/	20/	<input type="checkbox"/>	<input type="checkbox"/>	Are corrective lenses required when driving?
			Medical License No. (if different from below) [][][][][] - [][][][][]		Date (m/d/yyyy, if different from below)

X
(Examining Authority Signature, only if different from below)

SECTION A YES	SECTION A NO	APPLICANT completes section A when holding/applying for P and S endorsement.	HEALTH CARE PROFESSIONAL completes section B for applicant holding/applying for S endorsement.	SECTION B YES	SECTION B NO
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or other drug abuse or dependency within the past 12 months		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or other drug abuse or dependency within the past 12-24 months not controlled by treatment		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Muscular disease, e.g., ALS, MS, Head Trauma		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack, stroke, other cardiovascular condition		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date: _____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary disease or condition, positive TB communicable form, emphysema, COPD		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Required oxygen use		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Loss of body control, or altered consciousness Date: _____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy Date of last episode: _____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure over 180/105 (If yes, provide 3 BP readings taken over a 2-week period, separated by at least 1 day)		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Conditions		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot, leg		<input type="checkbox"/>	<input type="checkbox"/>
N/A	N/A	Inability to hear instructions given in normal conversational tone <input type="checkbox"/> Corrected by Hearing aid		<input type="checkbox"/>	<input type="checkbox"/>
N/A	N/A	Any medication that would interfere with the safe operation of a school bus		<input type="checkbox"/>	<input type="checkbox"/>
APPLICANT:		For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.			

I certify that the answers and statements made on this report are true and correct. I authorize the examining health care professional to release full details of an examination upon request to my employer, the School Board and the Wisconsin Department of Transportation.

X
(Applicant Signature) _____ (Date - m/d/yyyy)

HEALTH CARE PROFESSIONAL:	For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently. Please use the back of this form for additional comments, if needed.
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Would you recommend any additional medical evaluation?

Additional Comments:

This report must be based on an examination conducted within the past 90 days. I certify that I have examined this applicant and that I am licensed to practice (MD, DO, PA-C, APNP, DC).

Print Name	Patient Examination Date	(Area Code) Office Telephone No.
X (Authorized Signature)	Medical License No. [][][][][] - [][][][][]	National Registry No. - Chiropractor Only [][][][][] - [][][][][] - [][][][][]