Clear Form

MEDICAL EXAMINATION REPORT

MV3644 - 1 4/2023 Wis. Stat. Ch. 343 & Wis. Admin. Code Trans. 112
T583

Wisconsin Department of Transportation
Medical Review
P.O. Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

Applicant Name			Driver License Number	
Street Address			Birth Date	
City, State ZIP Code			(Area Code) Telephone Number	Other Type ☐ Behav ☐ Board ☐ Waiver
Date Report Issued (m/d/yy)	WisDOT Examiner Badge #	License Type ☐ CLP ☐ Instruction Permit	☐ CDL ☐ Operator	☐ Passenger Bus ☐ School Bus

Reason DMV is requesting information

HEALTH CARE PROFESSIONAL: Please complete all pertinent sections relative to this person's health to assist the Department in making a licensing decision. Incomplete forms will be rejected.

- ☐ **Driver Condition** or **Behavior Report** Attached. Driving Incident/Accident Date(s): _____
- ☐ **General Medical:** complete sections **A** and **G** (others if appropriate)
- ☐ **Mental/Emotional:** complete sections **A**, **B**, and **G**
- ☐ **Neurological:** complete sections **A**, **C**, and **G**
- ☐ **Endocrine: Diabetes, Nephrology, etc.** complete sections **A**, **D**, and **G**
- ☐ **Cardiovascular:** complete sections **A**, **E**, and **G**
- ☐ **Pulmonary:** complete sections **A**, **F**, and **G**

SECTION A HEALTH CARE PROFESSIONAL – To Complete for ALL Applicants

1. Please provide diagnoses, medications used and dosages. If issue is an event (like seizure, stroke, syncope, TBI, CVA, etc.) list the date of the last incident. Submit additional documents, if needed. If no diagnoses, say "None."

YES	NO	
☐	☐	2. Is the person's condition currently stable? **If not, explain below.**
☐	☐	3. Is the person reliable in following the treatment program? **If not, explain below.**
☐	☐	4. Does this person have side effects of medication which are likely to impair driving ability? **If yes, explain below.**
☐	☐	5. Has this person had an episode of altered consciousness or loss of bodily control during the past 12 months? **If yes, explain below and give date.**
☐	☐	6. Does current alcohol/drug abuse/use interfere with medical condition? **If yes, a substance evaluation will be required.**
☐	☐	a. Did the person have a seizure(s) related to withdrawal? **If yes, explain below and give date.**
☐	☐	7. Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy or other disorder? **If yes, explain below.**
		8. Is driving ability likely to be impaired by limitations in any of the following?
☐	☐	a. Judgment and insight
☐	☐	b. Problem-solving and decision-making
☐	☐	c. Emotional or behavioral stability
☐	☐	d. Cognitive function or memory loss
		9. Is driving ability likely to be impaired by limitations in any of the following?
☐	☐	a. Reaction time
☐	☐	b. Sensorimotor function
☐	☐	c. Strength and endurance
☐	☐	d. Range of motion
☐	☐	e. Maneuvering skills
☐	☐	f. Use of arm(s) and/or leg(s)

Details and Elaboration

Note: Sections B, C and D are on the next page (over)

SECTION B MENTAL/EMOTIONAL

YES NO

☐ ☐ 1. Mental/emotional disorder? If yes, What diagnosis? _____

☐ ☐ 2. Has the person been hospitalized? If yes, please provide us with the following:

a. Admission and discharge dates: _____

b. Discharge condition and recommendations for continued care: _____

_____

3. Identify any high-risk behaviors: _____

4. Identify current treatment program(s), counseling, etc.: _____

_____

☐ ☐ a. Compliant with treatment? _____

☐ ☐ b. Any medications that may have an adverse reaction if driving? _____

☐ ☐ 5. Does the person have any residual effects that could be a safety concern for driving? _____

_____

SECTION C NEUROLOGICAL

Medical Examiner: To be considered for a license, the medical examination must be **at least 60 days after the episode.** If last episode occurred within the past 90 days, the patient is not eligible to hold a license.

YES NO

☐ ☐ 1. Neurological disease? If yes, What diagnosis? _____

☐ ☐ 2. Did this person have a seizure within the past 90 days?

☐ ☐ 3. Give date of last episode of altered consciousness/loss of bodily control *no matter when it was*.

Date: _____ (mm/dd/yyyy) *Minimally, need month and year to accept the report*

☐ ☐ 4. Does this person have a seizure disorder? **If not, explain cause and/or diagnosis related to episode(s).**

_____

☐ ☐ 5. List anticonvulsant medication: _____ If discontinued, give date: _____

☐ ☐ 6. Does this person's neurological condition involve movement disorder? If yes, please explain: _____

_____

SECTION D ENDOCRINE: Diabetes, Kidney Disease, etc.

YES NO

☐ ☐ 1. Endocrine disease? If yes, What diagnosis? _____

☐ ☐ 2. Please provide a hemoglobin A_1C reading _____ (Reading) _____ (Date)

☐ ☐ 3. Does this person have hypoglycemic reactions requiring assistance? If yes, please explain frequency and provide date of last reaction: _____

☐ ☐ 4. Does this person demonstrate how to counter these reactions? _____

☐ ☐ 5. Has this person been hospitalized for treatment of diabetes or complications in the past year? If yes, give the date(s) and explain the reason below.

_____

6. Indicate type of medication and dosage for current treatment. _____

☐ ☐ 7. Is this person experiencing renal failure/CKD? Is dialysis required? What is the treatment schedule, if any? What are the residual effects, if any? What type of dialysis?

_____

☐ ☐ 8. Does this person monitor his/her blood sugar?

9. Provide the last 3 fasting blood sugar readings and dates recorded. (Home monitoring results ARE acceptable.)

_____ (Reading/Date) _____ (Reading/Date) _____ (Reading/Date)

10. When was this person diagnosed with diabetes? _____

a. When was insulin first prescribed? _____ Is this person currently treated with insulin? Yes ☐ No ☐

☐ ☐ b. Do any complications or associated conditions exist? If yes, please explain: _____

☐ ☐ c. Has patient completed any type of diabetic education? If yes, when? _____

SECTION E CARDIOVASCULAR

YES NO

☐ ☐ 1. Cardiovascular disease? If yes, what diagnosis: _____

2. Functional Class: ☐ I ☐ II ☐ III ☐ IV

☐ ☐ 3. Does the person have an implantable cardioverter defibrillator? If yes, give implant date: _____

a. Has patient been medically cleared by an electrophysiologist for:

*Motor vehicle (car or motorcycle): Yes ☐ No ☐

*Commercial motor vehicle (CDL): Yes ☐ No ☐

*School or passenger bus: Yes ☐ No ☐

b. Name of electrophysiologist: _____

☐ ☐ 4. Has the unit discharged since the implant? If yes, describe the person's condition at the time and date of discharge.

_____

_____

Has this person had any of the following? Please explain any yes answers.

☐ ☐ 5. Cardiovascular surgery and/or other procedure(s)? If yes, describe and give date(s):

_____

_____

_____

6. List all current cardiac symptoms or if no symptoms say "None." _____

_____

_____

☐ ☐ 7. Syncope due to cardiovascular condition? If yes, please list date of last episode _____

☐ ☐ 8. Dyspnea at rest? If yes, does it interfere with safe driving? Yes ☐ No ☐

☐ ☐ 9. Fatigue at rest?

☐ ☐ 10. Have any cardiac tests been conducted (exercise stress test, etc.)? **If yes, give procedure(s), date(s), results.**

_____

_____

_____

_____

SECTION F PULMONARY

YES NO

☐ ☐ 1. Pulmonary Disease? If yes, what diagnosis: _____

☐ ☐ 2. Continuous oxygen use required? If so, describe treatment regimen and provide number of liters: _____

_____

☐ ☐ 3. Dyspnea at rest? If yes, does it interfere with safe driving? Yes ☐ No ☐

☐ ☐ 4. Fatigue at rest?

☐ ☐ 5. Syncope from cough? Please explain cause and resolution: _____

_____

☐ ☐ 6. Provide Pulse Oximetry: Room Air _____ Oxygen _____

☐ ☐ 7. List Pulmonary Function Test Results:

_____

_____

☐ ☐ 8. Does the pulmonary disease prevent activities of daily living? If yes, please identify.

_____

_____

Note: Section G is on the next page (over)

SECTION G HEALTH CARE PROFESSIONAL Recommendations for ALL Applicants

Medical Examiner

This report must be based on an exam conducted within THE PAST 90 DAYS unless otherwise stated in the next sentence. If the DMV requires the exam to be completed more recently than 90 days, there will be a date written here: Exam date since: _____

YES NO

☐ ☐ 1. In your opinion, is this person medically safe to operate a motor vehicle (car/motorcycle)? (Checking "NO" will result in automatic cancellation of driver license)

☐ ☐ 2. In your opinion, is this person medically safe to operate a commercial motor vehicle?

☐ ☐ 3. In your opinion, is this person medically safe to operate a bus and/or school bus?

☐ ☐ 4. If YES to Question #1 above, do you recommend a complete re-examination of this patient's driving ability: knowledge of rules of the road, signs and skills test, or just skills test?

☐ ☐ 5. If applicable, I reviewed the attached Driver Condition or Behavior Report.

☐ ☐ 6. Recommended Restrictions:

- ☐ Continuous Oxygen Use Required
- ☐ Daylight driving only
- ☐ Drive only _____ miles from home (number of miles must be indicated)
- ☐ No freeway or Interstate Highway
- ☐ Roads posted _____ mph (choose from 25-55)
- ☐ Other enforceable restrictions _____

☐ ☐ 7. Do you recommend any additional medical evaluation?

I certify that I have examined this patient. My specialty is: _____

To accept this report, all information regarding the healthcare provider & the exam date must be completed in full.

Print Name of Reporting Health Care Professional	Check One: ☐ MD ☐ PA-C ☐ DO ☐ APNP	Patient Examination Date
		Professional License Number
X (Signature of Reporting Health Care Professional)		(Area Code) Office Telephone Number

Per WI Statute chapter 448.01 and Trans Ch. 112.02, this form must be signed by an MD, DO, PA-C or APNP.

The Secretary of the Department of Transportation is, by statute, responsible for the driver licensing decision. Your report will be advisory in determining eligibility.