



CERTIFICATE OF SUBSTANCE EXAMINATION BY COMPETENT AUTHORITY

MV3746 4/2019 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

Medical Review
Wisconsin Department of Transportation
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APPLICANT: After this report has been reviewed, you may be required to file follow-up reports.
We will send you the form at the required time.

Applicant Name		Driver License Number	
Street Address		Birth Date (m/d/yy)	
City, State, ZIP Code		(Area Code) Telephone Number	
Date Issued (m/d/yy)	Examiner Badge Number	License Type	<input type="checkbox"/> CDLI <input type="checkbox"/> School Bus <input type="checkbox"/> Instruction Permit <input type="checkbox"/> Operator <input type="checkbox"/> CDL <input type="checkbox"/> Passenger Bus

Date of Assessment and/or report must be completed based on an examination conducted within the past 90 days or since _____ (m/d/yy).

SECTION A Assessment Findings: Please assess this client's dependency level on alcohol or controlled substances or other drugs. (check all that apply)

Date of Last Use/Abuse (m/d/yy) _____

<input type="checkbox"/> Irresponsible Use of Alcohol (IU)	<input type="checkbox"/> Irresponsible Controlled Substance and/or Other Drug Use (IU)
<input type="checkbox"/> Irresponsible Use of Alcohol - Borderline (IUB)	<input type="checkbox"/> Irresponsible Use of a Controlled Substance and/or Other Drug Use
<input type="checkbox"/> Suspected Alcohol Dependency	<input type="checkbox"/> Suspected Controlled Substance Dependency and/or Other Drug
<input type="checkbox"/> Alcohol Dependency	<input type="checkbox"/> Controlled Substance and/or Other Drug Use Dependency
<input type="checkbox"/> Alcohol Dependency in Remission	<input type="checkbox"/> Controlled Substance and/or Other Drug Use Dependency in Remission

Please check drinking pattern and chronicity for alcohol dependency or suspected alcohol dependency findings.

Drinking Pattern	Chronicity
<input type="checkbox"/> Intermittent <input type="checkbox"/> Recurrent <input type="checkbox"/> Steady	<input type="checkbox"/> Early <input type="checkbox"/> Moderately Advanced <input type="checkbox"/> Far Advanced

SECTION B Treatment Recommended (check all that apply)

No Treatment

Driver is to abstain from all mood altering substances

Outpatient Treatment: _____ (Regimen) _____ (Date Completed or Expected Completion – m/d/yy)

Inpatient Treatment: _____ (Regimen) _____ (Date Completed or Expected Completion – m/d/yy)

Aftercare: _____ (Regimen) _____ (Date Completed or Expected Completion – m/d/yy)

SECTION C

Is applicant currently compliant with recommended treatment?

YES NO If NO, please explain: _____

X _____ (Counselor's Signature) _____ (Date Signed – m/d/yy)

_____ (Counselor's Title) _____ (Area Code – Office Telephone Number)

_____ (Office – Street Address, City, State, ZIP Code)