

STATE OF DELAWARE DEPARTMENT OF TRANSPORTATION  
DIVISION OF MOTOR VEHICLES  
DRIVER IMPROVEMENT UNIT - MEDICAL RECORDS SECTION  
PO BOX 698 - DOVER, DE 19903-0698

**MEDICAL REPORT OF PHYSICIAN'S FINDINGS**

Name: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ License Number: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby authorize Doctor \_\_\_\_\_ to perform any medical examination necessary for the purpose of determining my fitness to operate a motor vehicle. Also I understand that this authorization includes permission for the Director of Motor Vehicles and/or their designee to have this information reviewed by a Medical Board of unidentified physicians for the purpose of giving him/her a medical opinion on my case for a guidance in determining my medical capabilities to operate a motor vehicle safely. The information contained in this report is confidential and will be used solely for the purpose of drivers license considerations.

\_\_\_\_\_  
Date Signature of Applicant (*Required*)

*(Legibility is a must)*

Mental level for reading (check one)  Inadequate  Marginal  Adequate Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**(A) ORTHOPEDIC AND NEUROMUSCULAR:** (*Please check as appropriate*)

Spastic, Amputations or Ankylosed Joints  YES  NO Joint Ataxia, Paralysis, or Weakness  YES  NO

Prosthetic Devices used for Driving  YES  NO Other Deformities or Abnormalities  YES  NO

If **YES** to any of the above, please describe: \_\_\_\_\_

**(B) CARDIO-VASCULAR:** (*Please check as appropriate*)

Strokes - Adams Syndrome  YES  NO Syncope  YES  NO Vertigos  YES  NO  
Angina Pectoris  YES  NO Arteriosclerosis  YES  NO Arrhythmia  YES  NO  
Cardiac Decompensation  YES  NO Dyspnea  YES  NO Blood Pressure \_\_\_\_\_

If **YES** to any of the above, please describe: \_\_\_\_\_

**(C) DIABETES:** (*Please check as appropriate*)

Is he/she a known diabetic?  YES  NO Status of Control \_\_\_\_\_

Duration: \_\_\_\_\_ Diabetic Acidosis  YES  NO \_\_\_\_\_

If **YES** to any of the above, please describe: \_\_\_\_\_

**(D) HEARING:** Normal?  YES  NO If **NO**, please describe: \_\_\_\_\_

**(E) DRUGS AND/OR ALCOHOL:** (*Please check as appropriate*)

Any objective evidence or personal knowledge of addiction, habituation, or alcoholism?  YES  NO

If **YES**, please explain: \_\_\_\_\_

(F) **PSYCHOLOGICAL ASSESSMENT:** *(Please check as appropriate)*

Is there any evidence of emotional instability?  YES  NO Is further examination suggested?  YES  NO

Does he/she have or has he/she had any episodes of conditions listed below?

Mental Clouding  YES  NO Blackouts  YES  NO Dizziness  YES  NO

Unconsciousness  YES  NO Convulsions  YES  NO

If **YES** to any of the above, please explain nature and date of last episode: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

(G) Does he/she have any other condition or diseases which would decrease ability to safely operate a motor vehicle? *(Please check as appropriate)*  YES  NO

If **YES**, please explain: \_\_\_\_\_

(H) What type(s) and quantities of drugs are being prescribed for the patient? \_\_\_\_\_

(I) Do any of the above medications affect driving ability? *(Please check as appropriate)*  YES  NO

If **YES**, please explain: \_\_\_\_\_

(J) From a medical standpoint, do you feel he/she is capable of operating a vehicle safely?  YES  NO

If **NO**, please explain: \_\_\_\_\_

If **YES**, the treating physician must attest to one of the two below listed statements, as may be applicable, for any person who is subject to loss of consciousness due to disease of the central nervous system.

I hereby certify that I am the treating physician duly, licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's infirmity is under sufficient control to permit him/her to operate a motor vehicle with safety to person and property.

I hereby certify that I am the treating physician, duly licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's disease no longer requires treatment and that such person can reasonably expect to suffer no further losses of consciousness on account of such disease.

(K) How long have you been treating this patient? \_\_\_\_\_ Date of last examination: \_\_\_/\_\_\_/\_\_\_

(L) Additional comments: \_\_\_\_\_

Physician's Name (Printed or typed)

Physician's Signature

Address

Phone Number

Date: \_\_\_\_\_

Please mail form to: MEDICAL RECORDS SECTION - DRIVER IMPROVEMENT UNIT - PO Box 698 - Dover, DE 19903-0698

The form may be transmitted by facsimile to: (302) 739-5667 ATTN.: MEDICAL RECORDS SECTION