PHYSICIAN'S STATEMENT OF EXAMINATION

Michigan Department of State
P.O. Box 30810, Lansing, Michigan 48909-9832
Phone: 517-335-7051; Fax: 517-335-2189; email: MedicalForms@Michigan.gov
Michigan.gov/SOS

Reason for Referral (to be completed by Department of State personnel or referring health care provider)

Reason for Referral: _____

_____

Driver indicated a loss or impairment of consciousness within last: ☐ 6 months ☐ 12 months or more Date: _____

Driver may have a medical condition that could affect safe driving within the last: ☐ 6 months ☐ 12 months or more

Name and Title of Referrer: _____

Signature of Referrer: _____ Telephone _____

Instructions for Driver/Applicant

1. Complete Sections 1 through 4 with all of the information that applies to you. Please print or type.
2. Have your physician complete the other sections. The information in this form must be based upon an examination within three months from the date of your physician's certification.
3. Either you or your physician may return the completed form by fax, mail, or email (see contact information above). This form must be received by the department within three months after your physician signs it.

SECTION 1: Driver/Applicant Information

Name (First, Middle, Last)	Date of Birth	Driver's License Number	
Street Address		Telephone Number 8 a.m. – 5 p.m.	
City	State	ZIP	Today's Date

SECTION 2: History

Do you have, or have you had, any of the following conditions? Check all that apply:

☐ Cardiovascular problems or disease
☐ Diabetes
☐ Head or spinal injuries
☐ Mental or psychiatric problem or disease
☐ Neurological problems or disease
☐ Orthopedic, musculoskeletal, bone, joint or muscle problems or disease
☐ Physical impairments
☐ Seizures, blackouts, convulsions, or fainting
☐ Sleep disorders
☐ Substance Use/Abuse

Please explain any conditions checked above: _____

_____

_____

_____

Please list any other health problems: _____

_____

SECTION 3: General Questions for Driver/Applicant

1. How many traffic accidents have you been involved in while driving in the past 5 years? _____ ☐ None
2. Were you injured in any traffic accidents? ☐ Yes ☐ No

   If yes, please describe your injuries: _____

   Was treatment given? ☐ Yes ☐ No If yes, where was treatment given? _____
3. Describe any loss of consciousness or any impairment of consciousness in the past 5 years: _____

   _____ ☐ None

   Did you tell your doctor about the event(s)? ☐ Yes ☐ No

   If yes, what was the diagnosis for the event(s)? _____
4. Have you ever become lost when driving in familiar areas? ☐ Yes ☐ No
5. Has any family member or friend made a suggestion that you not drive or limit your driving? ☐ Yes ☐ No
6. Have you ever been told by a doctor to limit or stop driving? ☐ Yes ☐ No
7. How many times in the past 5 years have you had contact with police as a result of a traffic stop or accident?

   _____ ☐ None
8. Do you require a passenger to assist you when driving? ☐ Yes ☐ No
9. Please list all medications you are currently prescribed and/or taking: _____

   _____
10. How many alcoholic drinks do you consume per day? _____ Per week? _____ Per month? _____
11. Have you had treatment or a recommendation for treatment for any of the following? :
    Alcohol Use ☐ Yes ☐ No Illicit Drug Use ☐ Yes ☐ No Prescription Drug Use ☐ Yes ☐ No
12. Do you wear or use any of the following corrective lenses? Check all that apply:
    ☐ Glasses ☐ Contacts ☐ Telescopic Lens Device ☐ Other: _____
13. Do you have any progressive or degenerative diseases of the eye? Check all that apply: ☐ Retinitis Pigmentosis
    ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Other: _____
14. How often do you drive at night? ☐ Regularly ☐ Sometimes ☐ Never
15. How often do you drive on the freeway? ☐ Regularly ☐ Sometimes ☐ Never
16. How many miles do you drive per day? _____ Per week? _____ Per month? _____
17. How often do you wear your seatbelt? ☐ Always ☐ Sometimes ☐ Never

SECTION 4: Driver/Applicant Certification

I hereby authorize the release of information to the Department of State only for the purpose of assisting in evaluating my ability to safely operate a motor vehicle. I am aware that the Department of State may contact my physician for clarification or follow-up. I certify that my responses contained in this document are true and accurate to the best of my knowledge and belief.

Driver Applicant's Signature: _____

If you assisted the driver/applicant with the completion of this form, please complete the following information.

Name	Telephone Number	Relationship to Driver/Applicant	
Address	City	State	Zip

I am completing Sections 1 through 4 of this form at the request of the driver/applicant.

Signature: _____ Date: _____

PHYSICIAN'S STATEMENT OF EXAMINATION

Instructions for Physician

1. Review statements on pages one and two. You may contact the Driver Assessment Section at 517-335-7051 for additional information regarding the reason for referral.
2. Complete Sections 5 through 7 based upon an examination within three months from the date of your certification. Please print or type your answers and attach additional pages if necessary.
3. Either you or the patient may return this form to the department by fax, mail, or email (see top of page 1 for contact information). It must be received within three months after your certification.

SECTION 5: General Questions for Physician

1. How long has the patient been under your care?_____ Date of most recent medical exam _____

2. Do you have concerns about the patient's physical or mental capability to safely operate a motor vehicle? ☐ Yes ☐ No

   Please explain: _____

3. If applicable, please check the following cognitive tests that were administered to the patient and list any concerns:

	Intact	Impaired			Intact	Impaired
☐ Mini Mental State Exam	☐	☐	_____/30	☐ Trails A&B:	☐	☐
☐ Clock Drawing	☐	☐		☐ Other: _____	☐	☐

   Concerns: _____

4. If applicable, please check the following functional tests that were administered to the patient and list any concerns:

	Intact	Impaired		Intact	Impaired
☐ Rapid Pace Walk	☐	☐	☐ Range of Motion – Head and Neck Rotation Test	☐	☐
☐ Manual Test of Motor Strength	☐	☐			
			☐ Other: _____	☐	☐

   Concerns: _____

5. Do you recommend the department request an assessment of the patient's?

Visual Condition	☐ Yes	☐ No	Psychiatric/Psychological Condition	☐ Yes	☐ No
Substance Use	☐ Yes	☐ No	Other _____	☐ Yes	☐ No

   If yes, please explain: _____

6. What types of driving restrictions, if any, do you recommend the Department of State should consider based upon the patient's medical condition(s) (e.g., adaptive equipment, daylight driving only, trip lengths, trip radius, etc.)?

   Please specify: _____

7. Should the department require periodic medical evaluations to monitor changes in the patient's condition? ☐ Yes ☐ No

   If yes, specify condition and evaluation frequency: _____

8. Do you recommend an on-the-road driving evaluation? ☐ Yes ☐ No

SECTION 6: Current Diagnoses, Medications, Treatment and Prognosis

Complete the following diagnoses sections, in the order of importance, for the medical condition(s) that may affect the patient's ability to safely operate a motor vehicle. Attach additional pages if necessary.

PRIMARY DIAGNOSIS

Diagnosis: Symptoms: Age at onset:	The patient's condition is (check all that apply): ☐ Episodic ☐ Chronic ☐ Progressive	Prescribed Medication	Dosage	Start Date

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Supporting facts for prognosis:

Treatment or therapy plan:

Is the condition adequately controlled with medication, treatment or therapy? ☐ Yes ☐ No ☐ N/A
Comments:

Is another medical specialist involved in treatment of this condition? ☐ Yes ☐ No
If yes, name and specialty:

Has the patient reported a loss of, or impairment of consciousness? ☐ Yes ☐ No
If yes, please describe:

Date of last episode: Frequency:

If the patient experienced an episode or medical event, is there reasonable medical evidence it was due to a medically supervised change in medication or dosage? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

Comments:

SECONDARY DIAGNOSIS

Diagnosis: Symptoms: Age at onset:	The patient's condition is (check all that apply): ☐ Episodic ☐ Chronic ☐ Progressive	Prescribed Medication	Dosage	Start Date

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Supporting facts for prognosis:

Treatment or therapy plan:

Is the condition adequately controlled with medication, treatment or therapy? ☐ Yes ☐ No ☐ N/A
Comments:

Is another medical specialist involved in treatment of this condition? ☐ Yes ☐ No
If yes, name and specialty:

Has the patient reported a loss of, or impairment of consciousness? ☐ Yes ☐ No
If yes, please describe:

Date of last episode: Frequency:

If the patient experienced an episode or medical event, is there reasonable medical evidence it was due to a medically supervised change in medication or dosage? ☐ Yes ☐ No ☐ N/A
If yes, please explain:

Comments:

TERTIARY DIAGNOSIS

Diagnosis:	The patient's condition is (check all that apply):	Prescribed Medication	Dosage	Start Date
Symptoms:	☐ Episodic ☐ Chronic			
Age at onset:	☐ Progressive			

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Supporting facts for prognosis:

Treatment or therapy plan:

Is the condition adequately controlled with medication, treatment or therapy? ☐ Yes ☐ No ☐ N/A

Comments:

Is another medical specialist involved in treatment of this condition? ☐ Yes ☐ No

If yes, name and specialty:

Has the patient reported a loss of, or impairment of consciousness? ☐ Yes ☐ No

If yes, please describe:

Date of last episode: Frequency:

If the patient experienced an episode or medical event, is there reasonable medical evidence it was due to a medically supervised change in medication or dosage? ☐ Yes ☐ No ☐ N/A

If yes, please explain:

Comments:

SECTION 7: Physician's Certification

Name (First, Middle, Last)	M.D. or D.O.	Professional License Number	
Address	City	State	ZIP
Telephone Number	Type of Practice or Medical Specialty		

As of this date, I certify that I have reviewed Sections 1 through 4 and completed Sections 5 through 7 and that this Physician's Statement of Examination is true to the best of my knowledge and belief based on information obtained from the patient, the patient's known medical history, and a patient examination. I understand that the decision to grant, suspend, or reinstate an individual's driving privileges rests solely with the Department of State, which may consider other facts or conditions when making this decision.

Physician's Signature: _____ **Date:** _____
(Required)

Sign below if this form was completed by a psychologist, physician's assistant, or nurse practitioner.
Note: Nurse Practitioner signature must include supervising physician's countersignature.

PSY/PA/NP Signature: _____ Date: _____

For Driver Assessment Use Only

☐ FAVORABLE ☐ COME-UP DATE _____

☐ RESTRICTION _____

☐ MUST PASS _____

☐ UNFAVORABLE _____

☐ QUESTIONABLE _____

☐ REFER FOR REEXAMINATION _____

☐ NEED ADDITIONAL INFORMATION _____

☐ MEDICAL ☐ VISION ☐ SKILLS TESTING ☐ SUBSTANCE USE DISORDERS EVALUATION

REVIEWED BY: _____ DATE: _____