



MISSOURI DEPARTMENT OF REVENUE
 DRIVERS LICENSE BUREAU
 P.O. BOX 200
 JEFFERSON CITY, MO 65105-0200

TELEPHONE: (573) 751-2730
 FAX: (573) 522-1037

PHYSICIAN'S STATEMENT

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE COMPLETING THIS FORM!

You should complete the Physician's Statement based on your examination of the patient and indicate if he or she is capable of operating a motor vehicle safely and responsibly.

- ▶ Complete the entire form and sign your name on the reverse side.
- ▶ Completing this report does not violate physician/patient privilege and when made in good faith the physician shall be immune from any civil liability that might otherwise result from making this report.

PATIENT INFORMATION	PATIENT NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
	PATIENT'S MAILING ADDRESS	CITY	STATE	ZIP CODE

MEDICAL CONDITIONS		PLEASE CHECK <input checked="" type="checkbox"/> APPROPRIATE BOXES IF THE PATIENT BEING REPORTED HAS ANY OF THE FOLLOWING CONDITIONS THAT WOULD IMPAIR HIS OR HER ABILITY TO SAFELY OPERATE A MOTOR VEHICLE.

VISUAL IMPAIRMENT

	Yes	No
Should patient be required to wear glasses/lenses while driving?	<input type="checkbox"/>	<input type="checkbox"/>
Should patient be restricted to daylight driving?	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have visual field deficit which makes driving unsafe?	<input type="checkbox"/>	<input type="checkbox"/>

Additional comments: _____

VISION			
DISTANT VISION ONLY	RIGHT	LEFT	BOTH
WITH PRESENT CORRECTION	20/	20/	20/
WITHOUT CORRECTION	20/	20/	20/
BEST POSSIBLE CORRECTION	20/	20/	20/
FIELD	RIGHT	° LEFT	°

HEARING

Normal Other (Describe fully) _____

COGNITIVE IMPAIRMENT

Impaired Problem Solving, Decision Making or Judgment

Dementia

Other (Please explain) _____

PSYCHIATRIC

Hallucinations or Delusions

Other (Please explain) _____

DISORDERS THAT IMPAIR CONSCIOUSNESS

Medication Effect Disorders, such as Sleep Apnea, Narcolepsy, Other

Epilepsy, Seizure Disorder, Other

Blackouts
Date of Event with Impaired Consciousness _____

Other (Please explain) _____

MUSCULOSKELETAL CONDITIONS

Paralysis Loss of Limb

Restricted Range of Motion

Other (Please explain) _____

ALCOHOL OR DRUG ABUSE

(Please explain) _____

OTHER CONDITIONS

(Please explain) _____

PLEASE ATTACH ADDITIONAL COMMENTS IF NECESSARY.

STATEMENT OF PHYSICIAN

DIAGNOSIS/ASSESSMENT

CONDITION IS

Permanent Temporary (Please explain)

Are you the patient's regular physician? Yes No

If yes, how many times have you seen patient in the past year? _____

If no, have you reviewed the patient's medical records? _____

I have examined _____ on _____ and in my opinion he/she is is not capable of operating a motor vehicle safely and responsibly.

I recommend a written test and/or driving skills test to review the driving ability of this patient.

I RECOMMEND THE FOLLOWING SPECIAL RESTRICTIONS AND/OR DEVICES WHILE DRIVING:

PHYSICIAN'S SIGNATURE



DATE

PHYSICIAN'S NAME (PRINT OR TYPE)

MEDICAL LICENSE NUMBER

TELEPHONE NUMBER

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PHYSICIAN'S ADDRESS

CITY

STATE

ZIP CODE