On ______________ I examined ________________________________ date of birth ________________________ to determine his or her mental and physical fitness to operate a motor vehicle. My findings are as follows:

**General Health**
1. Is there any nervous, organic, or functional disease which has advanced, or is likely to advance during the next 12 months, to a degree that will interfere with safe driving?
   - [ ] Yes  [ ] No
2. Has the applicant ever been treated or received medication for any nervous disorders (muscular dystrophy, multiple sclerosis, cerebral palsy)?
   - [ ] Yes  [ ] No
3. Has the applicant ever been treated for epilepsy?
   - [ ] Yes  [ ] No

**Mental Condition**
4. Has a loss of alertness or mental activity adversely affected the applicant’s ability to handle emergencies frequently encountered in driving?
   - [ ] Yes  [ ] No

**Physical Condition**
5. Has the applicant lost any of the following members?
   - [ ] Yes  [ ] No
   - [ ] Finger  [ ] Hand  [ ] Arm  [ ] Leg
   a. Is there any partial or total loss of use of any of the above that impairs safe driving ability?
      - [ ] Yes  [ ] No
   b. Is there any other bodily defect or limitation that is likely to hinder safe driving?
      - [ ] Yes  [ ] No
   c. Does the car have special controls?
      - [ ] Yes  [ ] No

**Hearing**
6. Does the applicant need a hearing aid to hear ordinary conversation?
   - [ ] Yes  [ ] No

**Vision**
7. Has the applicant ever had cataracts?
   - [ ] Yes  [ ] No
8. Has the applicant lost the use of either eye?
   - [ ] Yes  [ ] No
9. Is there any opacity of the crystalline lenses of either or both eyes?
   - [ ] Yes  [ ] No
10. Visual acuity with corrective lenses
    Both Eyes if same: 20/________ Left Eye: 20/________ Right Eye: 20/________
11. Do the above visual acuity ratings suggest an inability to safely operate a motor vehicle?
    - [ ] Yes  [ ] No
12. Please explain any “Yes” answers above:
    __________________________________________________
    __________________________________________________
    __________________________________________________
    __________________________________________________

I have examined the above-named person and attest that these responses are true. In my professional opinion, the above-named person is in adequate health for the safe operation of a motor vehicle.

Name of Examining Physician __________________________ Signature of Examining Physician ________________ Phone Number ___________ Date ___________