

# PHYSICAL EXAMINATION REPORT

## For S or P Endorsement

MV3030B 6/2007 Ch. 343 Wis. Stats.

**Incomplete forms will be returned for completion.**

Wisconsin Department of Transportation  
Medical Review  
P O Box 7918  
Madison, WI 53707-7918  
Telephone: 608-266-2327; FAX: 608-267-0518  
E-mail: dre.dmv@dot.state.wi.us

|                      |                              |
|----------------------|------------------------------|
| Applicant Name       | Operator License Number      |
| Street Address       | Birth Date                   |
| City, State ZIP Code | Area Code - Telephone Number |

Note: Pursuant to Trans 112, Wis. Admin. Rules (copy available upon request), this report is to be completed prior to consideration for licensing. The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver's licensing. Any charges or fees for the medical examination and preparation of Section B is the responsibility of the applicant (driver). Contact the Department of Public Instruction at 608-266-2146 regarding questions about the TB requirement.

### Section A HEALTH: Applicant completes this section when applying/holding for P and S endorsement.

YES NO

- Alcohol or other drug abuse or dependency controlled by treatment
- Alcohol or other drug abuse or dependency within the past 12 months
- Alcohol or other drug abuse or dependency within the past 12-24 months
- Diabetes or elevated blood sugar controlled by:  Diet  Pills  Insulin
- Heart disease or heart attack, stroke, other cardiovascular condition
- Lung disease, emphysema, asthma, chronic bronchitis
- Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
- Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
- Heart surgery (Valve replacement/bypass, angioplasty, pacemaker, AICD)  
Date \_\_\_\_\_

YES NO

- Blood pressure over 180/105
- Kidney disease, dialysis
- Mental/Emotional Functions
- Missing or impaired hand, arm, foot, leg
- Positive TB in a communicable form
- Required oxygen use
- Loss of, or altered consciousness  
Date \_\_\_\_\_
- Seizures, epilepsy  
Episode Date \_\_\_\_\_

For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the answers and statements made on this report are true and correct. I authorize the examining physician to release full details of an examination upon request to my employer, the School Board and the Wisconsin Department of Transportation.

X

(Applicant Signature)

(Date)

### Section B HEALTH: Health Care Professional completes this section for applicant applying/holding for S endorsement.

Numerical readings must be provided.

REQUIRED

| ACUITY    | UNCORRECTED | CORRECTED | TEMPORAL FIELD OF VISION IN ° |
|-----------|-------------|-----------|-------------------------------|
| Right Eye | 20/         | 20/       | Right Eye                     |
| Left Eye  | 20/         | 20/       | Left Eye                      |

Can the applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors?  Yes  No  
Are corrective lenses required when driving?  Yes  No  
Examining Authority Signature & Medical License No. (If different from below)

X

YES NO

- Alcohol or other drug abuse or dependency controlled by treatment
- Alcohol or other drug abuse or dependency within the past 12 months
- Alcohol or other drug abuse or dependency within the past 12-24 months
- Diabetes or elevated blood sugar controlled by:  Diet  Pills  Insulin
- Heart disease or heart attack, stroke, other cardiovascular condition
- Inability to hear with or without hearing aid, instruction given in normal conversational tone
- Lung disease, emphysema, asthma, chronic bronchitis
- Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
- Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
- Heart surgery (Valve replacement/bypass, angioplasty, pacemaker, AICD)  
Date \_\_\_\_\_

YES NO

- Blood pressure over 180/105
- Kidney disease, dialysis
- Mental/Emotional Functions
- Missing or impaired hand, arm, foot, leg
- Positive TB in a communicable form
- Required oxygen use
- Loss of, or altered consciousness  
Date \_\_\_\_\_
- Seizures, epilepsy  
Episode Date \_\_\_\_\_

For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

**This report must be based on an examination conducted within the past 90 days.**

**I certify that I have examined this applicant and that**

**I am licensed to practice \_\_\_\_\_ (MD, DO, PA, DC, MSN, FNP, GNP, RN).**

|                      |                                              |                                |  |
|----------------------|----------------------------------------------|--------------------------------|--|
| Print Name           | Patient Examination Date: Month - Day - Year |                                |  |
| Authorized Signature | Medical License No.                          | Area Code-Office Telephone No. |  |

X