MEDICAL EXAMINATION REPORT

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Wisconsin Department of Transportation
Medical Review
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APPLICANT: After this medical report has been reviewed, you may be required to file medical reports on a regular basis. We will send you the forms at the time they are required.

Applicant Name		Operator License Number
Street Address		Birth Date
City, State, ZIP Code		Area Code and Telephone Number
Date Issued	Examiner Badge Number	License Type ☐ Instruction Permit ☐ Operator ☐ CDLI ☐ CDL ☐ Passenger Bus ☐ School Bus

Reason for Referral

Physician/Advanced Practice Nurse Prescriber (APNP): Please complete all pertinent sections relative to this person's health to assist the Department in making a licensing decision.

- ☐ 1. Driver Condition or Behavior Report Attached. Driving Incident/Accident [Date(s)] __________________.
- ☐ 2. General Medical: complete sections A and G (others if appropriate)
- ☐ 3. Mental / Emotional: complete sections A, B, and G
- ☐ 4. Neurological: complete sections A, C, and G
- ☐ 5. Endocrine (Diabetes): complete sections A, D, and G
- ☐ 6. Cardiovascular: complete sections A, E, and G
- ☐ 7. Pulmonary: complete sections A, F, and G

SECTION A: Physician/APNP - To Complete for ALL Applicants

Provide Diagnoses, Medications Used, and Dosages

Height	Weight

Yes	No	
☐	☐	1. Is the person's condition currently stable? **If not, explain below.**
☐	☐	2. Is the person reliable in following the treatment program? **If not, explain below.**
☐	☐	3. Does this person experience side effects of medication which are likely to impair driving ability? **If yes, explain below.**
☐	☐	4. Has this person experienced an episode of altered consciousness or loss of bodily control during the past 12 months? **If yes, explain below and give date.**
☐	☐	5. Does current alcohol/drug abuse/use interfere with medical condition? **If yes, a substance evaluation will be required.**
☐	☐	a. Did the person have a seizure(s) related to withdrawal? If yes, provide date(s) __________________.
☐	☐	6. Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy, or other disorder? **If yes, explain below.**
☐	☐	7. Is driving ability likely to be impaired by limitations in any of the following?
☐	☐	a. Judgment and insight
☐	☐	b. Problem-solving and decision-making
☐	☐	c. Emotional or behavioral stability
☐	☐	d. Cognitive function
		8. Is driving ability likely to be impaired by limitations in any of the following?
☐	☐	a. Reaction time
☐	☐	b. Sensorimotor function
☐	☐	c. Strength and endurance
☐	☐	d. Range of motion
☐	☐	e. Maneuvering skills
☐	☐	f. Use of arm(s) and/or leg(s)

Details and Elaboration

Note: Sections B, C and D are on the next page (over).

SECTION B: MENTAL / EMOTIONAL

Yes No

☐ ☐ 1. Has the person been hospitalized in the past year for a mental/emotional condition? If yes, give admission date(s), reason(s) for admission and date(s) of discharge: ____________________

____

☐ ☐ 2. Does the person have a behavior disorder which is likely to impair driving ability?

3. Identify current treatment program(s), counseling, etc.

____

____

SECTION C: NEUROLOGICAL

Examining physician: If an episode has occurred in the past 90 days, the examination must be **at least 60 days after the episode**.

1. Give date of last episode of altered consciousness or loss of bodily control. If last episode occurred within the previous 3 months, the patient is not eligible to hold a license. ____________________ (Month / Day / Year)

Yes No

☐ ☐ 2. Does this person have a seizure disorder? **If not, explain cause and/or diagnosis related to episode(s).**

____

3. List anticonvulsant medication: ____________________ If discontinued, give date: ____________________

☐ ☐ 4. Was the last medication blood serum level within acceptable range?

☐ ☐ 5. Does this person's neurological condition involve movement disorder? If yes, please explain. ____________________

____

6. If this person holds or is applying for a commerical driver license, and has had an episode of altered consciousness or loss of bodily control since the last report was filed with WDOT, the following is required:
   a. A narrative summary, including the history of the episode(s);
   b. An indication of risk for further episodes;
   c. Current blood levels of anticonvulsant medication;
   d. Results of the most recent EEG.

SECTION D: ENDOCRINE

1. Please provide a hemoglobin A_1C reading: ____________________ (Reading) ____________________ (Date)

Yes No

☐ ☐ 2. Does this person have hypoglycemic reactions? If yes, please explain and provide date of last reaction. ____________________

____

☐ ☐ 3. Does this person demonstrate how to counter these reactions?

☐ ☐ 4. Has this person been hospitalized for treatment of diabetes or complications in the past year? If yes, explain below.

____

5. Indicate type of medication and dosage for current treatment. ____________________

____

☐ ☐ 6. Is this person experiencing renal failure? If yes, what is their current treatment regimen? ____________________

____

☐ ☐ 7. Does this person monitor his/her blood sugar?

8. Provide the last 3 fasting blood sugar readings and dates recorded. (Home monitoring results ARE acceptable.)

(Reading)	(Date)	(Reading)	(Date)	(Reading)	(Date)

9. If this person holds or is applying for a commercial license, and is taking insulin as a NEW treatment in the past 2 years, please provide the following information:
   a. When was this person diagnosed with diabetes? ____________________
   b. When was insulin first prescribed? ____________________.

Yes No

☐ ☐ c. Do any complications or associated conditions exist? If yes, please explain: ____________________

____

SECTION E: CARDIOVASCULAR

1 . Functional Class

☐ I ☐ II ☐ III ☐ IV

Yes No

☐ ☐ 2. Does the person have an implantable cardioverter defibrillator? If yes, give implant date ______

☐ ☐ 3. Has the unit discharged since the implant? If yes, describe the person's condition at the time and date of discharge.

______

______

4. List all current cardiac symptoms. ______

______

______

______

Has this person had any of the following? Please explain any yes answers.

Yes No

☐ ☐ 5. Cardiovascular surgery and/or other procedures - describe and give date(s) ______

______

☐ ☐ 6. Syncope ______

☐ ☐ 7. Fatigue ______

☐ ☐ a. With exertion ______

☐ ☐ b. At rest ______

☐ ☐ 8. Dyspnea ______

☐ ☐ 9. Pulmonary symptoms ______

☐ ☐ 10. Have any cardiac tests been conducted (exercise stress test, etc.)? **If yes, give procedure(s), date(s), results.**

______

______

______

SECTION F: PULMONARY

Yes No

☐ ☐ 1. Pulmonary Disease? If so, what? ______

☐ ☐ 2. Continuous Oxygen Use Required? If so, describe treatment regimen and provide number of liters. ______

______

☐ ☐ 3. Dyspnea at rest?

☐ ☐ 4. Fatigue at rest?

☐ ☐ 5. Syncope from cough?

Please explain cause and resolution. ______

6. Provide Pulse Oximetry: Room Air ______ Oxygen ______

7. List Pulmonary Function Test Results ______

______

______

☐ ☐ 8. Does the pulmonary disease prevent activities of daily living? If yes, please identify. ______

______

______

______

__Note:__ **Section G is on the next page (over).**

SECTION G: Physician's/APNP's Recommendations for ALL Applicants

Reporting Physician/APNP: This report must be based on an examination conducted WITHIN THE PAST 90 DAYS or since _______________. The Secretary of the Department of Transportation is, by statute, responsible for the driver licensing decision. Your report will be advisory in determining eligibility. **Physician's/APNP's signature AND ALL recommendations (Section G) are required for ALL applicants**.

Yes	No		
☐	☐	1.	In your opinion, is this person medically safe to operate a motor vehicle?
☐	☐	2.	In your opinion, is this person medically safe to operate a commercial motor vehicle?
☐	☐	3.	In your opinion, is this person medically safe to operate a bus and/or school bus?
☐	☐	4.	If applicable, I reviewed the attached Driver Condition or Behavior Report.
☐	☐	5.	Re-examination by DOT (Vision Screening, Knowledge, Highway Signs and Road Test).
☐	☐	6.	Recommended Restrictions:

- ☐ Continuous Oxygen Use Required
- ☐ Daylight Driving Only
- ☐ ______ miles from home
- ☐ Other: ____

____

I certify that I have examined this patient. My speciality is: ________________________________ .

Print Name of Reporting Physician	Check One: ☐ MD ☐ DO ☐ APNP	Patient Examination Date: Month - Day - Year	
Signature of Reporting Physician X		Professional License Number	Area Code - Office Telephone Number

Pursuant to Chapter 448.01(5), Wis. Statutes and Trans Ch. 112.02(16), Wis. Admin. Code, this form must be signed by an MD, DO, or APNP.