TIM TIPTON
COMMISSIONER

J. KEVIN STITT
GOVERNOR

STATE OF OKLAHOMA
DEPARTMENT OF PUBLIC SAFETY

Dear Medical Professional:

The bearer of this medical examination form has been requested to undergo a medical examination by a licensed physician or appropriate medical professional. **The completion of this form must be based on an examination performed within the last sixty (60) days.**

THE APPLICANT WILL BE RESPONSIBLE FOR ANY PROFESSIONAL FEE CHARGED FOR THE EXAMINATION.

This medical examination is required under one or more of the following categories:

(1) All original applicants who have known medical conditions which may affect their driving ability.

(2) Any driver who indicates to an investigating officer at the scene of an accident that he/she did not know the cause of the accident because of a "blackout" or seizure.

(3) All licensed drivers who have physical impairments which mayaffect their driving ability.

(4) Any person reported by a verifiable source as having questionable physical or mental capacities to safely operate a motor vehicle.

Respectfully,

MEDICAL STANDARDS SECTION
DEPARTMENT OF PUBLIC SAFETY

AUTHORIZATION AGREEMENT

This medical examination authorization agreement must be completed and signed by the applicant to allow the Department of Public Safety to review the medical information for driver license purposes.

* * * * * * * * *

I hereby authorize the following physician(s) who may have attended me and/or the hospital(s) or clinic(s) in which I may have been treated, to give the Department of Public Safety any information theymay request concerning my condition.

___________________________	___________________________
PHYSICIAN	HOSPITAL OR CLINIC
___________________________	___________________________
PHYSICIAN	HOSPITAL OR CLINIC

I understand that this authorization includes permission for the Department of Public Safety to have this information reviewed by the Oklahoma Driver License Medical Advisory Committee for the purpose of giving the Department a medical opinion on my case for guidance in determining my physical or mental capabilities to operate a motor vehicle safely, in the interest of the general public.

___________________________	___________________________
DATE	SIGNATURE OF LICENSEE/APPLICANT

PRINT FULL LEGAL NAME____

MAILING ADDRESS______________________________ City ST, ZIP ____________________

DOB____________________ DL#____________________

NEUROLOGICAL EXAMINATION

(To be completed by a Neurologist or the treating Physician)

1. Patient history of lapse, loss or alteration of consciousness level, or other event resultingin loss of muscular control:

A) Type of episode(s) the patient has experienced (grand mal, partial, nocturnal, etc.):

(1) Primary ____

(2) Secondary____

(3) Other____

B) Description of episode(s):

C) Approximate age at onset:________Did the initial episode result in LOC? Yes ____ No _____

D) Is there any regularity in their occurrence? Yes ____ No _____

If yes, please explain____

____

2. Results of EEG (If available): ____

3. Anti-convulsant medication prescribed (name and dosage):

________________________ ________________________

________________________ ________________________

________________________ ________________________

If no longer on anti-convulsant medication, the date it was discontinued ____________________

4. What is your assessment of this patient's current status? (Check those applicable)

A) _____Completely controlled

B) _____Occasional seizures while awake

C) _____OCCASIONAL seizure during sleep

D) _____Uncontrolled

5. Number of episodes *within the past six (6) months* resulting in loss, lapse, or alteration of consciousness____________________Date of the last episode______________________

Note: If the person has experienced any episode(s) involving loss, lapse, or alternation of consciousness within the last six (6) months, please advise if you would consider the episode(s) to fit into either of the following categories and explain below:

A) The episode resulted from a deliberate change in medication ordered by the physician

B) The episode was an isolated occurrence, and another episode is unlikely to occur with reasonable medical certainty.

Explanation____

____

6. List any other significant ailments or conditions:

____

____

7. From a medical standpoint, do you feel this person is safe to drive a motor vehicle?

Yes ____ No _____

Comments or recommendations ____

____

8. Remarks or points of clarification:

____

____

____

DATE OF THIS EXAMINATION _______________

____
SIGNATURE OF PHYSICIAN

____
PRINT NAME OF PHYSICIAN

____
SPECIALTY

____
LICENSE# AND STATE OF

____
MAILING ADDRESS

____
CITY, STATE, AND ZIP

____
TELEPHONE NUMBER

The medical professional must submit the completed form.

Please mail forms directly to

Medical Standards Section
Department of Public Safety
PO Box 53004
Oklahoma City, OK 73152-9998

Or fax the completed form to 405-497-7035