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/shedid 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#_____

This form must be completed by a licensed physician, or a licensed physician qualified in mental health issues

1. **Is this individual prone to act on sudden impulses without regard for the consequences of his or her behavior?**

   Yes ____ No _____

   COMMENTS _____

2. **Do you consider this individual to have sufficient regard for his or her personal safety to operate a motor vehicle safely?**

   Yes ____ No _____

   COMMENTS _____

3. **Does this individual have sufficient regard for the safety of others to operate a motor vehicle safely?**

   Yes ____ No _____

   COMMENTS: _____

4. **Please provide any comments regarding this individual's emotional adjustment which would *favor* issuing or retaining a driver license:**

   _____

5. **Comments regarding this individual's emotional adjustment which would *contraindicate* issuing or retaining a driver license:**

   _____

6. **What is the patient's diagnosis?** _____

7. **How long have you been treating this patient?** _____

8. **Medications currently prescribed:**

_____ _____

_____ _____

Is there evidence that these medications and/or dosages could affect driving ability?

Yes ____ No _____

If yes, please explain_____

If medication has been discontinued, provide the name of the medication and the date discontinued

_____ _____

_____ _____

9. **List any other significant medical conditions.**

_____

10. **In your professional judgment, is the condition of the patient stable?**

Yes ____

Is the patient capable of demonstrating rational decisions? Yes_____ No _____
Length of current stable period_____

No ____

Please explain: _____

_____

11. **Within the last twelve (12) months, has the patient been required to have inpatient treatment?**

Yes_____ No_____ Date of Hospitalization: _____

12. **Other comments** _____

_____
DATE OF EXAMINATION

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

_____
PRINTED NAME OF DOCTOR

_____
SIGNATURE OF DOCTOR

_____
SPECIALTY

_____
LICENSE # AND STATE OF

_____
MAILING ADDRESS

_____
CITY, STATE, AND ZIP

(_____)_____
TELEPHONE