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

P.O. BOX 53004 • OKLAHOMA CITY, OK 73152 • 3600 NORTH M.L. KING AVENUE • OKLAHOMA CITY, OK 73111 • (405) 425-2424

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

____
PRINTED NAME OF DOCTOR

____
SIGNATURE OF DOCTOR

____
SPECIALTY

____
LICENSE # AND STATE OF

____
MAILING ADDRESS

____
CITY, STATE, AND ZIP

(_______)___________________________
TELEPHONE

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