



CONFIDENTIAL EYE/MEDICAL/MENTAL EXAMINATION REPORT

Name (Last, First)	Driver License Number	Date of Birth
Street Address	City, State, Zip Code	Daytime or Home Phone Number

PART I: RELEASE OF INFORMATION BY PATIENT

I hereby authorize my physician or hospital to answer any questions from the Division of Motor Vehicles, or its employees relating to my physical or mental condition, and/or alcohol use or abuse, and to release any related information or records to the Division of Motor Vehicle or its employees. Any expense involved is to be charged to me and not the State of Alaska.

I hereby authorize the Division of Motor Vehicles to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

Signed: _____ Date: _____

Witness: _____

PART II: GENERAL PATIENT INFORMATION

A. How long has this person been your patient? _____ Date of last examination: _____

Is your patient under a controlled medical program or regimen? Yes No

If yes, how long has control been maintained? _____

Is the patient adhering to the medical regimen? Yes No, please explain: _____

B. Please list any medications, currently prescribed for medical conditions, with side effects that could interfere with the safe operation of a motor vehicle?: _____

SECTION I: EYE EXAMINATION AND PHYSICIAN OR OPTOMETRIST ASSESSMENT

Visual Acuity: Right Eye _____ Left Eye _____ Progressive Eye Disease: _____

Will the eye disease affect the person's ability to drive safely: Yes No

From your assessment of the visual history, visual examination, medications, and laboratory data, and in consideration of public safety, will the patient be able to safely operate a motor vehicle? Yes No

Special Restrictions Recommended: Corrective Lenses Outside Mirrors Daylight driving only

Other _____ Re-evaluation recommended : Date _____

Examiner's Name (Please Print) _____ Title _____

Signature _____ Date of Evaluation _____

Address _____ Phone _____

SECTION II: MEDICAL EXAMINATION AND PHYSICIAN OR NEUROLOGIST ASSESSMENT

A. CONDITIONS THAT MAY AFFECT THE SAFE OPERATION OF A MOTOR VEHICLE

1. Please identify any diseases or disorder that may cause loss of consciousness or control of motor functions at any time:

Epilepsy Narcolepsy Diabetes Cerebral vascular disease Other: _____

Is condition under control? Yes No

2. Please identify any disease or condition that may affect the safe operation of a motor vehicle:

Memory Loss Diminished judgment Impaired motor function Alzheimer's disease

Neurological or neuromuscular disease Confusion Diminished concentration Other dementia

Reaction, or impairment due to change in medication or dosage Other metabolic disorder

Substance abuse: Alcohol Narcotics

Other: _____

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SECTION II: MEDICAL EXAMINATION CONTINUED

3. Diagnosis: _____

Is the condition: Improving Stable Worsening or deteriorating Subject to change
4. From your assessment of the medical history, physical examination, medications, and laboratory data, and in consideration of public safety, will the patient be able to safely operate a motor vehicle? Yes No
If no, have you informed the applicant? Yes No Suggested re-evaluation date, if applicable _____

What, if any, medical restrictions and/or prostheses would be necessary to ensure the safe operation of a motor vehicle?
 Prostheses _____ Hand controls Automatic transmission
 Day light driving Other _____

REMARKS: _____

Examiner's Name (Please Print) _____ Title _____
Signature _____ Date of Evaluation _____
Address _____
Phone Number _____

B: REPORT OF LOSS OF CONSCIOUSNESS OR SEIZURE EPISODE

A re-examination or cancellation letter was sent to the patient by the DMV. The action was taken because the DMV received a report that stated: _____ Episode occurred on _____

I have discussed the incident that caused the cancellation letter with my patient. Yes No

Was the episode due to a medical condition? No Yes Diagnosis: _____
If yes, is condition under control? Yes No

From your assessment of the medical history, physical examination, medications, and laboratory data, and in consideration of public safety, will the patient be able to safely operate a motor vehicle? Yes No

Examiner's Name (Please Print) _____ Title _____
Signature _____ Date of Evaluation _____
Address _____ Phone Number _____

SECTION III: MENTAL EXAMINATION AND PHYSICIAN, PSYCHIATRIST, OR PSYCHOLOGIST ASSESSMENT

Is the patient experiencing any emotional or mental conditions that could interfere with the safe operation of a motor vehicle? Yes No

If yes, is the condition under control? Yes No If no, is the condition? Improving Worsening/Deteriorating

Comments: _____

What, if any, restrictions would be necessary to ensure the safe operation of a motor vehicle?

From your assessment of the emotional or mental history, physical examination and laboratory data, and in consideration of public safety, will the patient be able to safely operate a motor vehicle? Yes No

Examiner's Name (Please Print) _____ Title _____
Signature _____ Date of Evaluation _____
Address _____ Phone _____

Please return completed form to the: **Division of Motor Vehicles/Anchorage Driver Licensing**
1300 W Benson Blvd., Ste 100
Anchorage, AK 99503-3689
Fax #: 907-269-3774