State of Alaska/ Division of Motor Vehicles
Anchorage Driver Services
3901 Old Seward Hwy, Ste 101
Anchorage, AK 99503

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: **X** _____ 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? O Yes O No
If yes, how long has control been maintained?_____

Is the patient adhering to the medical regimen? O Yes O 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

O Visual Acuity: Right Eye_____ Left Eye_____ O Progressive Eye Disease: _____
Will the eye disease affect the person's ability to drive safely: O Yes O 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? O Yes O No

Special Restrictions Recommended: O Corrective Lenses O Outside Mirrors O Daylight driving only

O Other _____ O 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:
O Epilepsy O Narcolepsy O Diabetes O Cerebral vascular disease O Other:_____
Is condition under control? O Yes O No

2. Please identify any disease or condition that may affect the safe operation of a motor vehicle:
O Memory Loss O Diminished judgment O Impaired motor function O Alzheimer's disease
O Neurological or neuromuscular disease O Confusion O Diminished concentration O Other dementia
O Reaction, or impairment due to change in medication or dosage O Other metabolic disorder
O Substance abuse: O Alcohol O Narcotics
O Other:_____

CONFIDENTIAL EYE/MEDICAL/MENTAL EXAMINATION REPORT

SECTION II: MEDICAL EXAMINATION CONTINUED

3. Diagnosis:_____

_____

_____

Is the condition: O Improving O Stable O Worsening or deteriorating O 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? O Yes O No

If no, have you informed the applicant? O Yes O 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?

O Prostheses _____ O Hand controls O Automatic transmission

O Day light driving O 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. O Yes O No

Was the episode due to a medical condition? O No O Yes Diagnosis:_____

If yes, is condition under control? O Yes O 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? O Yes O No

Examiner's Name (Please Print)_____ Title_____

Signature_____ Date of Evaluation_____

Address_____ Phone Number_____

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

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

If yes, is the condition under control? O Yes O No If no, is the condition? O Improving O 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? O Yes O 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 Services
3901 Old Seward Hwy, Ste 101
Anchorage, AK 99503
Fax #: 907-269-3774 Email: doa.dmv.ads@alaska.gov