



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 may affect 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 they may 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 resulting in 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:**

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

Yes \_\_\_\_ No \_\_\_\_

Comments or recommendations \_\_\_\_\_

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**8. Remarks or points of clarification:**

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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