

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/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
Legal Division
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# _____

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** *(Only list medications relevant to the current diagnosis):*

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 submit completed forms to:

By mail:
Medical Standards Section
Department of Public Safety
PO Box 53004
Oklahoma City, OK 73152

By email: medicaldesk@dps.ok.gov