



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# _____

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:

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

Yes ____ No ____

Comments or recommendations _____

8. Remarks or points of clarification:

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 submit completed forms to:

By mail:
**Medical Standards Section Department of
Public Safety
PO Box 53004
Oklahoma City, OK 73152-9998**

By email:
medicaldesk@dps.ok.gov