

**INITIAL REPORTING FORM**

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION



Bureau of Driver Licensing  
P.O. Box 68682  
Harrisburg, PA 17106-8682  
(717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12

PROVIDER: For more information relating to Medical Reporting, visit <http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml>.**SECTION A PATIENT INFORMATION**

DRIVER'S LICENSE NO.		LAST NAME(S)			JR. ETC	FIRST NAME	
HEIGHT FEET    INCHES		SEX	EYE COLOR	DATE OF BIRTH MONTH    DAY    YEAR		TELEPHONE NUMBER	SOCIAL SECURITY NUMBER
STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.				CITY			STATE    ZIP CODE

DATE OF EXAMINATION: \_\_\_\_\_

How long have you been treating the patient? \_\_\_\_\_

**SECTION B****DIAGNOSIS OF DISORDER OR DISABILITY: Please Check (✓) Appropriate Items**

<input type="checkbox"/> Loss or Impairment of a Foot, Leg, Finger, Thumb, or Hand - Condition: _____	<input type="checkbox"/> Cognitive impairment: _____
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Neuropsychiatric Disorder: _____
<input type="checkbox"/> Cerebral Vascular Disease	<input type="checkbox"/> Psychiatric Disorder: _____
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Vision Deficiency: <input type="checkbox"/> Acuity <input type="checkbox"/> Visual Fields
<input type="checkbox"/> Loss of Consciousness - Cause: _____	<input type="checkbox"/> Other Medical Condition that would interfere with the patient's ability to drive. Explain: _____
<input type="checkbox"/> Neurological Disorder	
<input type="checkbox"/> Neuromuscular Disorder: _____	
<input type="checkbox"/> Single Seizure: Date of Seizure: _____	
<input type="checkbox"/> Seizure Disorder: <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Last Seizure: _____	

NOTE: A seizure disorder- More than one seizure or a single seizure of electrically diagnosed epilepsy.

**Patient meets following seizure waiver, therefore no action should be taken on the driving privilege:**

- 2 year history of strictly a nocturnal pattern of seizures or a pattern of seizures occurring only immediately upon awakening
- 2 year history of a specific prolonged aura accompanied by sufficient warning
- Patient has been seizure free for the previous 6 months and above referenced seizure occurred as a result of a prescribed change in or removal from medication. Patient's previous medication has been reinstated.
- Patient has been seizure free for previous 6 months and above referenced seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance.

Should this individual cease driving immediately? .....  YES  NOIf not, does the condition(s) warrant further investigation of driving competency by the Department? .....  YES  NO**SECTION C**

Please indicate whether this person has any of the following:

Alcohol Use:  Yes  NoDrug or Controlled Substance Use:  Yes  No**SECTION D****ALL INFORMATION IS CONFIDENTIAL AS PROVIDED IN THE PA VEHICLE CODE, SECTION 1518(d)**

HEALTH CARE PROVIDER'S NAME		SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS		CITY	STATE	ZIP CODE
TELEPHONE NUMBER			FAX NUMBER	

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to \$2,500 and/or imprisonment up to 1 year.

Health Care Provider's Signature

Date

Return this form to the address listed at the top of the form or fax to (717) 705-4415  
If Additional Information is Required, Please Feel Free to Call Us at: (717) 787-9662