

INITIAL REPORTING FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION



pennsylvania
DEPARTMENT OF TRANSPORTATION

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	SEX	EYE COLOR	DATE OF BIRTH		TELEPHONE NUMBER		SOCIAL SECURITY NUMBER
FEET INCHES			MONTH	DAY	YEAR		
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

- | | |
|---|---|
| ☐ Loss or Impairment of a Foot, Leg, Finger, Thumb, or Hand - Condition: _____ | ☐ Cognitive impairment: _____ |
| ☐ Diabetes Mellitus | ☐ Neuropsychiatric Disorder: _____ |
| ☐ Cerebral Vascular Disease | ☐ Psychiatric Disorder: _____ |
| ☐ Cardiovascular Disease | ☐ Vision Deficiency: ☐ Acuity ☐ Visual Fields |
| ☐ Loss of Consciousness - Cause: _____ | ☐ Other Medical Condition that would interfere with the patient's ability to drive. Explain: _____ |
| ☐ Neurological Disorder | _____ |
| ☐ Neuromuscular Disorder: _____ | |
| ☐ Single Seizure: Date of Seizure: _____ | |
| ☐ Seizure Disorder: ☐ YES ☐ 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 reinstituted.
- ☐ 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