



WYOMING DEPARTMENT OF TRANSPORTATION

Driver Services
5300 Bishop Blvd
Cheyenne, WY 82009-3340
Phone: (307) 777-4810 Fax: 777-4817

CONFIDENTIAL

DRIVER MEDICAL EVALUATION

NAME (Printed) DATE OF BIRTH DL # or MVID # MAILING ADDRESS CITY STATE ZIP

Commercial Driver License

I hereby authorize my physician or hospital to answer any questions from the Department of Transportation, Driver Services program, or its employees relating to my physical or mental condition, and to release any related information or records to the Department of Transportation, Driver Services program, or its employees.

I understand that the Department of Transportation, Driver Services program, may receive any information relating to my physical or mental condition, and will use this information in determining whether I have the ability to safely operate a motor vehicle.

Signed: X Date:

DOCTOR: Your experience and knowledge of the patient's condition, results of medical examinations, and treatment plans will be of great value in assisting Driver Services to make a determination for proper licensing. PLEASE ANSWER ALL QUESTIONS THAT ARE APPLICABLE TO YOUR PATIENT'S CONDITION.

This form may be completed & signed by the treating: Physician, Physician's Assistant, Psychologist, Psychiatrist, or Advanced Practice Registered Nurse.

(Type or Print Legibly) (For acceptance, patient's last examination must have been within the previous 3 months)

1. How long has this person been your patient? Date of last examination:

2. DIAGNOSIS: How long has the condition(s) existed?

Principle symptoms/limitations:

If patient has Epilepsy, Seizures, or a Seizure Disorder:

Loss of consciousness Loss of muscular/physical control Date of last episode:
Diurnal Nocturnal

If patient has Diabetes:

Insulin Dependent Non-Insulin Dependent
Additional Information:

3. MEDICATION:

- Patient's condition can be treated by medication; and has been medically controlled for at least three (3) months.
Patient's condition cannot be controlled by medication; however, patient has been stable for at least three (3) months.
Patient's condition is currently being evaluated for an effective medication regimen.
Patient is not compliant with their medication regimen and should not be operating a motor vehicle at this time.

4. **RECOMMENDATIONS:**

- An independent evaluation from a specialist in another field for the purpose of determining driving safety.

Type of evaluation recommended: _____

- A Driver Medical Evaluation must be submitted annually to the department to determine if patient meets licensing standards.

Restriction Recommendations for Operating a Motor Vehicle:

- Daylight Driving Only
- Automatic Transmission
- No Interstate Driving
- Prosthetic Aide: _____
- Special Adaptive Devices/Equipment: _____
- Specific Limits of Time/Distance _____
- Other restrictions: _____
- No recommendations at this time

5. **IN MY PROFESSIONAL OPINION:**

- Patient's condition does not affect the safe operation of any type of motor vehicle.
- Patient's condition does not affect the safe operation of a private motor vehicle; however, he/she should not drive a heavy/commercial vehicle.
- Patient's condition is such that his/her ability to **safely** operate a motor vehicle should be re-examined:
 - immediately
 - upon license renewal
 - at the discretion/observation of a licensing examiner
- Patient's condition renders him/her incapable of **safely** operating a motor vehicle.

6. **COMMENTS/ADDITIONAL INFORMATION:**

Printed Name of Treating Professional

Classification/Speciality

Address

City

State

ZipCode

Telephone

Authorized Signature
(Physician, Physician's Assistant, Psychologist, Psychiatrist,
or Advanced Practical Registered Nurse)

Date