

# STATEMENT OF PHYSICIAN

NEBRASKA DEPARTMENT OF MOTOR VEHICLES

Once completed, please mail or fax to: PO Box 94726 Lincoln, NE 68509

FAX: 402-471-4020 Email: dmv.vismed@nebraska.gov

**NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE**

(Applicant completes before exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my physical and psychological condition or history to the Department of Motor Vehicles, State of Nebraska.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Applicant's Signature)

I hereby certify that I examined \_\_\_\_\_  
(Applicant's Name)

of \_\_\_\_\_  
(Street Address) (City) (Zip Code)

Date of Birth \_\_\_\_\_ License Number \_\_\_\_\_

## **NEUROLOGICAL AND NEUROMUSCULAR DISEASES/CONDITION/INJURY:**

### **I. CONDITION CAUSING CONFUSION, MEMORY LOSS OR LOSS OF CONSCIOUSNESS (Check)**

- Epilepsy-Type: \_\_\_\_\_  Narcolepsy  
 Alcoholism (*complete Alcohol section below*)  Cerebral Vascular Disease  Other: \_\_\_\_\_
- Frequency of seizures: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_  
Reason for seizure: \_\_\_\_\_
- Frequency of loss of consciousness: \_\_\_\_\_ Date of last occurrence of loss of consciousness: \_\_\_\_\_  
Reason for loss of consciousness: \_\_\_\_\_
- Current medication and dosage: \_\_\_\_\_  
Have significant sedative or hypnotic effects occurred:  No  Yes  Explain: \_\_\_\_\_
- Is this condition likely to worsen in the near future affecting the person's ability to operate a motor vehicle?  No  Yes  
Explain: \_\_\_\_\_

### **II. OTHER LIMITING OR PROGRESSIVE NEUROLOGIC OR NEUROMUSCULAR DISEASES (CEREBRAL PALSY, PARAPLEGIA, MUSCULAR DYSTROPHY, PARKINSONISM, STROKE, MULTIPLE SCLEROSIS, ETC.)**

- Specific diagnosis: \_\_\_\_\_ Age at onset: \_\_\_\_\_
- Significant deterioration of neuromuscular function (strength, coordination) in the past year? \_\_\_\_\_
- Describe the patient's neuromuscular functional limitations (strength, coordination, etc.): \_\_\_\_\_

## **CONDITION CAUSING VERTIGO OR MULTIPLE EPISODES OF DIZZINESS OR FAINTING:**

- Specific diagnosis: \_\_\_\_\_ Date of last occurrence: \_\_\_\_\_
- Has condition been resolved? \_\_\_\_\_ Please explain: \_\_\_\_\_

## **DRUGS AND ALCOHOL EVALUATION:**

- Does the patient have or is there any objective evidence of addiction or habituation to drugs, tranquilizers or alcohol?  
 No  Yes If yes, type of drug and duration: \_\_\_\_\_
- Is patient currently under therapy?  No  Yes Explain: \_\_\_\_\_
- Evidence of physical complications of alcohol or drugs (please state): \_\_\_\_\_

## **PSYCHOLOGICAL EVALUATION:**

- Diagnosis of psychiatric illness: \_\_\_\_\_  
If any of the following symptoms are present please mark #1 or a #2  
1. Does not impair ability to operate a motor vehicle. 2. Impairs ability to operate a motor vehicle.  
( ) Anxiety ( ) Visual or auditory ( ) Impairment of judgment  
( ) Delusions ( ) Suicidal impulses or behavior ( ) Impairment of memory  
( ) Euphoria ( ) Homicidal impulses or behavior ( ) Daytime sleepiness  
( ) Hallucinations ( ) Paranoid ideation ( ) Other: \_\_\_\_\_  
( ) Intermittent Explosive Episodes ( ) Depression

To be completed by physician.

To be completed by physician.

**MEDICAL EVALUATION:**

**I. DIABETES**

Type:  Adult Onset  Juvenile Onset Duration: \_\_\_\_\_  
Insulin:  No  Yes Dose: \_\_\_\_\_  
Oral hypoglycemic agents.....  No  Yes Dose: \_\_\_\_\_  
Hypoglycemic reactions .....  No  Yes Frequency: \_\_\_\_\_  
Date of last reaction: \_\_\_\_\_  
Renal Disease.....  No  Yes BUN \_\_\_\_\_ Creatinine \_\_\_\_\_  
Retinopathy.....  No  Yes  
Should statement on vision be required?..  No  Yes

**II. ARTERIOSCLEROSIS**

Peripheral vascular disease.....  No  Yes \*  
Cerebral vascular disease.....  No  Yes \* \* If yes, please complete Section III, HEART DISEASE.  
Coronary vascular disease.....  No  Yes \*

**III. HEART DISEASE**

Diagnosis: \_\_\_\_\_  
Angina:  No  Yes Frequency: \_\_\_\_\_ Date of Onset: \_\_\_\_\_ During Driving:  No  Yes  
Lightheadedness:  No  Yes Syncope:  No  Yes  
Arrhythmia:  No  Yes Type: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Infarction:  No  Yes Number and dates: \_\_\_\_\_  
Congestive failure at present:  No  Yes Ever:  No  Yes  
Pacemaker:  No  Yes  
Blood Pressure: \_\_\_\_\_ Heart Rate: \_\_\_\_\_

**GENERAL STATEMENTS (THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY):**

- 1 In your professional opinion, is this patient mentally capable of operating a motor vehicle safely?  
 No  Yes  Only if appropriate tests as determined by the DMV are passed .
- 2. In your professional opinion, is this patient physically capable of operating a motor vehicle safely?  
 No  Yes  Only if appropriate tests as determined by the DMV are passed .
- 3. Do you feel that this patient should have a medical evaluation for the purpose of operating a motor vehicle safely?  
 No  Yes  If yes, how often? \_\_\_\_\_

If you wish to make additional comments, such as driving distance or day or night driving, or you have any recommended restrictions patient should have on license, please use space below or additional sheet(s) as necessary.

If there are any other medical conditions not shown on this report that would affect the patient's ability to safely operate a motor vehicle, please describe as to frequency, severity, etc.:

- 4. Based upon your examination, has the medical condition of this patient significantly worsened or another condition developed?  
 No  Yes If yes, please explain including how this affects the person's ability to safely operate a motor vehicle. \_\_\_\_\_

**For Commercial Motor Vehicle Operators Only:** Was this condition in existence prior to July 30, 1996?  No  Yes

**DATE OF EXAMINATION:** \_\_\_\_\_ **(MUST BE COMPLETED—STATEMENT OF PHYSICIAN NOT VALID 90 DAYS FROM EXAMINATION DATE.)**

Name (Print or Type) \_\_\_\_\_ M.D. or D.O.

Type of Practice \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_