PHYSICAL EXAMINATION REPORT

For S or P Endorsement

MV3030B 1/2013 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

Incomplete forms will be returned for completion.

Wisconsin Department of Transportation
Medical Review
PO Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

Applicant Name	Operator License Number
Street Address	Birth Date (m/d/yy)
City, State, ZIP Code	(Area Code) Telephone Number

Note: Pursuant to Trans 112, Wis. Admin. Rules (copy available upon request), this report is to be completed prior to consideration for licensing. The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver's licensing. Any charges or fees for the medical examination and preparation of Section B is the responsibility of the applicant (driver).

SECTION A APPLICANT completes this section when holding/applying for P and S endorsement.

YES	NO	
☐	☐	Alcohol or other drug abuse or dependency within the past 12 months
☐	☐	Alcohol or other drug abuse or dependency within the past 12–24 months not controlled by treatment
☐	☐	Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
☐	☐	Diabetes or elevated blood sugar controlled by: ☐ Diet ☐ Pills ☐ Insulin
☐	☐	Heart disease or heart attack, stroke, other cardiovascular condition
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date: _____
☐	☐	Pulmonary disease or condition, positive TB communicable form, emphysema
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring

YES	NO	
☐	☐	Loss of body control, or altered consciousness Date: _____
☐	☐	Seizures, epilepsy Episode Date: _____
☐	☐	Kidney disease, dialysis
☐	☐	Blood pressure over 180/105
☐	☐	Mental/Emotional Functions
☐	☐	Missing or impaired hand, arm, foot, leg
☐	☐	Required oxygen use

For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the answers and statements made on this report are true and correct. I authorize the examining health care professional to release full details of an examination upon request to my employer, the School Board and the Wisconsin Department of Transportation.

X _____
(Applicant Signature) (Date)

SECTION B HEALTH CARE PROFESSIONAL completes this section for applicant holding/applying for S endorsement.

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED
Right Eye	20/	20/
Left Eye	20/	20/

YES	NO	
☐	☐	Is the temporal field of vision at least 70 degrees from center in **each** eye?
☐	☐	Can the applicant recognize and distinguish the colors red, amber, and green?
☐	☐	Are corrective lenses required when driving?

Examining Authority Signature & Medical License No.: (If different from below) X _____

YES	NO	
☐	☐	Alcohol or other drug abuse or dependency within the past 12 months
☐	☐	Alcohol or other drug abuse or dependency within the past 12–24 months not controlled by treatment
☐	☐	Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
☐	☐	Diabetes or elevated blood sugar controlled by: ☐ Diet ☐ Pills ☐ Insulin
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☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date: _____
☐	☐	Pulmonary disease or condition, positive TB communicable form, emphysema
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Inability to hear instructions given in normal conversational tone ☐ Corrected by Hearing aid

YES	NO	
☐	☐	Loss of body control, or altered consciousness Date: _____
☐	☐	Seizures, epilepsy Episode Date: _____
☐	☐	Kidney disease, dialysis
☐	☐	Blood pressure over 180/105
☐	☐	Mental/Emotional Functions
☐	☐	Missing or impaired hand, arm, foot, leg
☐	☐	Required oxygen use
☐	☐	Any medication that would interfere with the safe operation of a school bus

For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

This report must be based on an examination conducted within the past 90 days.
I certify that I have examined this applicant
and that I am licensed to practice _____ (MD, DO, PA-C, DC, MSN, FNP, GNP, RN).

Print Name	Patient Examination Date	
X _____ (Authorized Signature)	Medical License No.	(Area Code) Office Telephone No.

T577 4/2012