PLEASE RETURN COMPLETED MEDICAL FORMS TO:

PH:
FAX:

STATE OF KANSAS DIRECTOR OF VEHICLES
DRIVER REVIEW SECTION
915 HARRISON STREET
PO BOX 2188
TOPEKA KS 66601-2188

SECTION I: GENERAL DRIVER INFORMATION

Driver must complete Sections I and II.

Name: ____________________ Date of Birth: ____________________

Address:____________________

Phone Number:____________________ Driver's License Number: ____________________

Are you enrolled in Driver's Education? YES ☐ NO ☐

Instructor's Name:____________________ Instructor's Phone #:____________________

Permission is granted for release of all medical information concerning me to the Kansas Division of Vehicles and to all medical professionals who complete any part of this form.

Dr. ____________________

Signature of Driver: ____________________ Date: ____________________

SECTION II: DRIVER MEDICAL HISTORY

If the answer to any of the following questions is "YES", please give sufficient details in the remarks area at the end of this section.

Have you experienced or been treated for any of the following conditions within the past three (3) years:

		Check One:	
1.	Motor Vehicle Accident	YES ☐	NO ☐
2.	Driver's License Revocation / Suspension / Cancellation	YES ☐	NO ☐
3.	Blackout Spells / Dizzy Spells / Epilepsy / Seizures / Loss or Alteration of Consciousness	YES ☐	NO ☐
	Date of last episode:		
4.	Other Neurological Impairments	YES ☐	NO ☐
5.	Head Trauma / Brain Surgery	YES ☐	NO ☐
6.	Nervousness	YES ☐	NO ☐
7.	Depression / Confusion / Other Psychiatric Disorders	YES ☐	NO ☐
8.	Memory Impairment	YES ☐	NO ☐
9.	Alcoholism	YES ☐	NO ☐
10.	Visual Impairment / Eye Disease	YES ☐	NO ☐
11.	Drug Abuse	YES ☐	NO ☐
12.	Hearing Impairment	YES ☐	NO ☐
13.	Amputations / Missing Extremities / Prosthesis	YES ☐	NO ☐
14.	Other Orthopedic Impairments	YES ☐	NO ☐
15.	High Blood Pressure	YES ☐	NO ☐
16.	Heart Disease / Cardiovascular Impairments	YES ☐	NO ☐
17.	Diabetes	YES ☐	NO ☐
18.	Other Diseases / Ailments/Complications: list below	YES ☐	NO ☐

Remarks: (Attach additional sheet if necessary)

SECTION III: PHYSICIAN'S REPORT

DL#: ____________________

TO THE PHYSICIAN: Please complete the sections of this report applicable to this patient's diagnosis and add comments related to any questions marked "YES" by the patient in Section II. The physician assumes no liability. See Kansas Statute Section 8-247 (d) (6).

- **If you are not a Psychologist, Psychiatrist or a Neurologist you must complete Section A and IV.**
- **If you are a Psychologist or Psychiatrist you must complete Section B and IV.**
- **If you are a Neurologist you must complete Section C and IV.**

A. PHYSICAL EXAMINATION

1. Other Physical Impairment(s) e.g. Diseases / Ailments / Complications

   Description: ____________________

   ____

   Diagnosis: ____________________

   ____

   Prognosis: ____________________

   ____

   Medication: ____________________

   ____

B. PSYCHOLOGICAL EVALUATION

Is there any evidence of any Psychological Dysfunction? E.G. Excessive Tension / Anxiety / Depression Hostility / Behavior Disorders / Paranoia / Suicidal Tendencies / Impairment of Judgment / Developmental or Delayed Disability / Hallucinations / Delusions

Check One: YES ☐ NO ☐

If "YES", please provide:

Diagnosis: ____________________

____

Prognosis: ____________________

____

Treatment: ____________________

____

Medications: ____________________

____

ALCOHOL/DRUG DEPENDENCE?

Check One: YES ☐ NO ☐

If "YES", please provide:

Diagnosis: ____________________

____

Prognosis: ____________________

____

Treatment: ____________________

____

Medications: ____________________

____

C. NEUROLOGICAL EVALUATION

DL#:________________________

Is there any evidence of a Seizure / Syncope Event / Blackout / Dizzy Spell Disorder? If "YES", please provide:

Check One:

YES ☐ NO ☐

1. Type of Seizure / Syncope Event / Blackout / Dizzy Spell Disorder: ______________________________

   DAY ☐ NIGHT ☐

   Date of Last Seizure / Syncope Event / Blackout / Dizzy Spell / Loss or Alteration of Consciousness: ______________________________

   Frequency:________________________

   Medication(s):______________________________

   EEG Report Result:______________________________

   Date of Report:________________________

2. **Other** Neurological Impairment(s)::

   Diagnosis:______________________________

   Progressive?______________________________

   Prognosis:________________________

   Medication(s):______________________________

   Check One:

   Any Loss or Alteration of Consciousness: YES ☐ NO ☐

   Date / Frequency of Last Loss / Alteration of Consciousness:____________________________

SECTION IV: PHYSICIAN'S CERTIFICATION

Description of Limitation(s). Include any effect this impairment may have on the patient's ability to safely operate a motor vehicle:

____

____

Recommendations / Restrictions to be placed on the License if issued: **(Limit 6)**

☐ Corrective Lenses	☐ Within City Limits	☐ Outside Mirror
☐ Daylight Hours Only	☐ Licensed Driver In Front Seat	☐ Automatic Transmission
☐ No Interstate / Freeway Driving	☐ Mechanical Aid	☐ (___)Miles From Home
☐ Outside Business Area	☐ Prosthetic Aid	(5-30 in 5 mile increments)

Check One:

Driver must take and pass a drive test at a Kansas Exam Station.	YES ☐		NO ☐
Annual Medical Report should be required.	YES ☐		NO ☐
Driver is reliable in taking medications?	YES ☐	NA ☐	NO ☐
Driver's medical condition is controlled?	YES ☐	NA ☐	NO ☐

Driver has been under my care for how long? ______________________________

In my professional opinion, I believe this person can safely operate a motor vehicle at this time in regards to their physical / mental state. (Driver must be considered a safe candidate in order to request a drive test.)

Check One: YES ☐ NO ☐

(Within the last 90 days)

Name of Physician:______________________________ **Exam Date:______________________________**

Physician License#:______________________________ Specialty:______________________________

Physician Address:______________________________ Phone#:______________________________

Other comments / recommendations to be considered regarding this driver's medical condition as it relates to his / her driving privileges:

____

Supervising Physician Signature:______________________________

Date:__________________________