State of Vermont
DEPARTMENT OF MOTOR VEHICLES
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Montpelier, VT 05603-0001

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UNIVERSAL MEDICAL EVALUATION/PROGRESS REPORT

****THIS EVALUATION MUST BE COMPLETED IN FULL OR IT WILL BE RETURNED****

ANY MEDICAL CHARGES INCURRED ARE THE RESPONSIBILITY OF THE PATIENT

PLEASE INDICATE REASON FOR THE EVALUATION

Complete Sections A, B, D & E if you are selecting one of the four reasons below. See front and back of form.

- ☐ Applying for a Vermont License/Permit
- ☐ School Bus Endorsement (Type II)
- ☐ Department Request
- ☐ New/Update Medical Condition

Complete ALL Sections if requesting a DISABLED PLACARD OR PLATES. See front and back of form.

- ☐ Disabled Parking Placard (must be accompanied by a Disabled Parking Placard Application ~ TA-VD-120)
- ☐ Disabled Parking Plate (must be accompanied by a Registration, Tax and Title Application ~ TA-VD-119)

A NOTE TO PARKING PLACARD APPLICANTS: THE INFORMATION IN THIS MEDICAL MAY BE CONSIDERED IN DETERMINING YOUR LICENSE STATUS

SECTION A - TO BE COMPLETED BY APPLICANT

PATIENT'S NAME:	
PATIENT'S MAILING ADDRESS:	**Street / Road / Box Number**
	City / State / Zip Code

Physical Address – If Different From Mailing Address

GENDER:	☐ MALE ☐ FEMALE	**CHECK-MARK THE APPROPRIATE BOX IF THE ABOVE IS A CHANGE TO YOUR:**	☐ MAILING ADDRESS ☐ PHYSICAL ADDRESS

DATE OF BIRTH	**SOCIAL SECURITY NUMBER**	**VT DRIVER LICENSE/ID NUMBER (If Applicable)**

IF THIS IS A NAME CHANGE, LIST FORMER NAME:

I CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. STATEMENTS AND WARRANTS HEREIN ARE CERTIFIED UNDER PENALTY OF 23 VSA §202 & §203.

➢ **APPLICANT'S SIGNATURE:**

SECTIONS B, C, D & E – TO BE COMPLETED BY MEDICAL EXAMINER

SECTION B

1. Patient has been under my care for _____ years.
2. Check-mark any/all of the following conditions that apply:

☐ **SEIZURES**	☐ **CANCER**	☐ **SPINAL INJURY**	☐ **HYPERTENSION**
☐ **DIABETES**	☐ **COPD**	☐ **ARTHRITIS/DEGENERATIVE JOINT DISEASE**	

☐ **AMPUTATION:**
ARM: ☐ Left ☐ Right
LEG: ☐ Left ☐ Right
Describe cause and extent (example: at elbow, below knee) of amputation:

☐ **PERMANENT DISABILITY/ CONDITION**:
Specify:

☐ **PSYCHIATRIC DISORDER**:
Specify:

3. Blood pressure reading is required for **all school bus driver medicals**. For other licensed drivers, only indicate if a medical condition exists.

Systolic:		**Diastolic:**	

DEPARTMENT USE ONLY SECTION			**MEDICAL DATE:**
RATER #:	**TRANSACTION TYPE:**	**TYPE:**	/
	☐ ADD ☐ UPDATE	☐ A – SCHOOL BUS ☐ B – NOT STABLE ☐ D – STABLE	**CURRENT YEAR** **CURRENT MONTH**

CONTINUED ~ SECTIONS C, D & E – TO BE COMPLETED BY MEDICAL EXAMINER

SECTION C – PARKING PLACARD/PLATES

I hereby attest to the fact that at the time of the examination the applicant:

Check-mark the applicable disability. **One must be check-marked**.

- ❑ Has an irreversible visual impairment, or
- ❑ Has an irreversible ambulatory disability within the meaning of 23 VSA §304a.

SECTION D – MEDICAL EXAMINER'S OPINION

1. I have examined the patient and in my opinion: (Check-mark one of the statements below.)
   - ❑ The patient **IS NOT** medically fit to drive any motor vehicle on the highway.
   - ❑ There are no reasonable **medical** grounds to limit driving privileges.
   - ❑ The patient is medically fit to drive a motor vehicle, however, they should:
     - ❑ Submit progress reports to the Department of Motor Vehicles every: _____ Months _____ Years
     - ❑ Be further evaluated for driving ability.

   Comments: _____

2. **Patient's condition is totally stable:** ❑ **Yes** ❑ **No**

SECTION E – MEDICAL EXAMINER'S CERTIFICATE

THIS FORM MUST BE COMPLETED BY A LICENSED PHYSICIAN, EXCEPT AS STATED BELOW.

1. If the medical is for School Bus requirements, it must be signed by a Licensed Physician, Physician Assistant or a Nurse Practitioner.
2. If the applicant has or is applying for a Vermont license, without a School Bus endorsement, the medical must be signed by a Licensed Physician. **Exception:** A Physician Assistant may sign the medical, if co-signed by a Licensed Physician.
3. If the applicant is applying for Disabled Parking Placard or Disabled Parking Plates, the medical must be signed by a Licensed Physician, Certified Physician Assistant or Licensed Advanced Practice Registered Nurse.

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. STATEMENTS AND WARRANTS MADE HEREIN ARE CERTIFIED UNDER PENALTY OF 23 VSA § 202.

DATE OF EXAM	
/ /	**DATE OF EXAM MUST BE ENTERED AT LEFT AND BE WITHIN THE LAST 6 MONTHS TO BE ACCEPTABLE.**

MEDICAL EXAMINER'S SIGNATURE	DATE

MEDICAL EXAMINER'S NAME (PRINT CLEARLY)	PHONE NUMBER

MEDICAL EXAMINER'S MAILING ADDRESS	STREET/ROAD/BOX NUMBER
	CITY/STATE/ZIP CODE

CLASSIFICATION OR SPECIALTY	TITLE	LICENSE STATE	LICENSE #