# MEDICAL REPORT

_____

(Applicant's Full Name)

NOTICE TO APPLICANT:

Please take this form to a licensed medical doctor or any other competent authority acceptable to the Examiner of Drivers. You are responsible for any expense involved. The Medical Advisory Board will review your medical report that will be identified by number only. The board will provide an opinion regarding your fitness to drive safely based on the guidance in the National Highway Safety Traffic Administration publication entitled, Medical Conditions and Driving, September 2005.

The County's Examiner of Drivers will review the board's opinion and decide whether you meet the standards required to operate a motor vehicle in the State of Hawaii.

NOTICE TO MEDICAL EXAMINER:

This applicant is required to undergo a medical examination to provide the driver licensing administrator information to decide whether the physical and mental standards to be licensed in this State are met. Your report will be reviewed by this agency and the Medical Advisory Board before the applicant is licensed. State laws make the licensing administrator responsible for the licensing action and your medical report is strictly advisory. Please be assured that your report will be used to grant driving privileges commensurate with driving ability while considering driving need and public safety.

Please complete the form for the medical condition in question so that we may be properly informed about the medical conditions that might impair safe driving ability. If your examination reveals other conditions that in your professional opinion might compromise the applicant's ability to drive safely, please provide the information. Consult with other medical authorities, if necessary.

The applicant is responsible for any professional fee for this examination. The AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION form is for your protection; it should be signed by the applicant and kept in your files.

Thank you for your assistance in this program.

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical history to the county examiner of drivers for deciding my eligibility for a driver's license by _____

(Name of licensed medical doctor or any other competent authority acceptable to the Examiner of Drivers)

_____

Signature of applicant Date

**NOTICE TO APPLICANT:**

You are given this Medical Evaluation Report (DOT-H 2058) to be completed and signed by a doctor (licensed to do physical examinations). The completed report must be submitted to our office within thirty (30) calendar days for review and may be forwarded to the State of Hawai'i Medical Advisory Board (MAB) for further review and recommendation. ***Failure to meet the requirement may result in the cancellation of your driver's license*** ***(Hawai'i Administrative Rule 19-122-354 & 355 effective 5/2/08).***

_____ _____

Signature of Applicant Date:

DOT-H2058 05/2018

**Hawaii Department of Transportation**

# MEDICAL REPORT

Please be advised that the decision to allow an applicant to continue to retain his/her Hawaii driver's license is contingent upon the information provided in this medical report. It is in the best interest of the applicant and the public, that all questions be answered completely. This report will be reviewed by a panel of physicians who may request additional medical information.

This form will become part of the applicant's record, is for confidential use of the physician, county DMVs, and the Hawaii Department of Transportation only.

Thank you for your assistance.

**ALL INFORMATION MUST BE TYPED OR CLEARLY PRINTED**

**DMV Use Only**

**Case #**

☐ OAHU ☐ HAWAII ☐ MAUI ☐ KAUAI

**Reason for Medical Report:**

## Applicant Information

| Applicant's Name (Last, First, Middle Initial) | | Age |
|---|---|---|
| Driver's License # | Telephone # | Sex (Circle One) M F |

## Physician's Report

How long have you treated this patient?

Date of last examination:

**A. Has the patient had loss of consciousness or alteration in awareness?** Yes □ No □

1. □ Syncope □ Seizures □ Hypoglycemia
   □ Other:

| 2. Frequency of events? | 3. Date of last event? |
|---|---|

4. Patient's condition is: □ Unstable □ Stable □ Unknown

5. Inciting/Modifying factors? □ Unknown

6. Describe any assistive device, (e.g. pacemaker, automatic implanted cardioverter, continuous glucose monitoring system, etc.) and give implant date.

**B. Does patient have physical impairments that affect safe driving?** Yes □ No □

1. □ Amputation □ Frozen joint(s) □ Decreased mobility

□ Weakness/ Hemiparesis/ Paraplegia □ Paralysis □ Parkinsonism
For Hemiparesis: (circle one) Left / Right

□ Other: _____
(For Visual or Hearing issues please see Sections E and F below)

2. How does it affect driving ability?

3. Patient's condition is: □ Unstable □ Stable □ Unknown

4. Modifying factors? Assistive devices?

5. How long has patient had impairment?

6. Has vehicle been modified to accommodate limitations?

7. How long has patient been using modification?

**C. Does patient have cognitive or psychological impairments that affect safe driving?** Yes □ No □

1. □ Dementia/Memory Impairment □ Severe Psychiatric Illness □ Danger to Self or Others

□ Other: _____
(For Alcohol or Substance Abuse, See section D Below)

2. How does it affect driving ability?

3.Patient's condition is: □ Unstable □ Stable □ Unknown

4. Modifying factors? Treatment?

**D. Does patient have a history of alcohol or substance abuse?** Yes □ No □

1. What substances have been abused within the last five years or are currently being abused?

2. Is your patient being treated for alcohol or substance abuse? (Medications, Psychiatry, AA, Other?)
Yes □ No □

3. Is your patient currently clean and sober? Yes □ No □ If yes, for how long?

## E. Does patient have a vision problem that may affect safe driving? Yes □ No □

1. Does the patient have any medical conditions that affect their vision (acuity or visual fields)? If yes, list condition(s) and provide the distance visual acuities and amount of visual fields for each eye.

| | Uncorrected | Corrected | Degrees |
|---|---|---|---|
| Right Eye | 20/ | 20/ | |
| Left Eye | 20/ | 20/ | |

2. Is the patient receiving any treatment that will modify their visual capability? Yes □ No □
If yes, list condition(s) and provide the amount of visual fields in each eye.

## F. Does patient have a hearing problem that may affect safe driving? Yes □ No □

1. Is this corrected with hearing aid? Yes □ No □

2. Patient's condition is: □ Unstable □ Stable □ Unknown

## Physician's Report

What medication(s) is the patient taking? How often? (please name drugs and attach additional page if needed) ☐ Medication Record Provided as Attachment

**DRUG** **DOSE** **SCHEDULE**

_____

_____

_____

_____

_____

## G. Summary

1. In your opinion is this person capable of safe driving? Yes □ No □
□ Other (Please explain):

2. Do you recommend a road test? Yes □ No □

3. Do you recommend the maximum licensing period? Yes □ (see below for the max. periods by age)
□ No, recommend a reduced validity period of _____ Year(s)

| Maximum Validity Period | Age 16-17 | Age 18-24 | Age 25-71 | Age 72+ |
|---|---|---|---|---|
| | 1 to 4 years | 4 years | 8 years | 2 years |

I certify that I am a licensed medical provider and have determined this applicant's physical and mental ability to operate a motor vehicle. I understand that my recommendations will be used by a county Driver Licensing Administrator to determine the eligibility of the applicant to be licensed in the State of Hawaii.

| Medical Examiner's Name (print clearly) | Date of Examination | Office Telephone # |
|---|---|---|
| Signature of licensed medical examiner | Medical License # | Specialty |