Clear Form

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 Report will be reviewed by your county's examiner of drivers. The examiner of drivers may request that the Medical Advisory Board (MAB) review the medical report and at that time the MAB will review your medical report identified by case number only. The MAB will provide an opinion regarding your fitness to drive based on the guidance in the National Highway Traffic Safety Administration publication entitled, Driver Fitness Medical Guidelines (latest edition), as well as any MAB revised medical criteria.

The county's examiner of drivers will review all reports and decide whether you meet the standards required to safely 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 county examiner of drivers 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 may also be reviewed by the Medical Advisory Board. State laws dictates that the examiner of drivers is 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 the applicant's 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 the applicant's 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 Report (DOT-H2058) to be completed and signed by a medical doctor (licensed to perform 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 for further review and recommendation. ***Failure to meet the requirement may result in the cancellation of your driver's license (Hawai'i Administrative Rule 19-122-355).*** The Medical Report's date of examination **must be within 6 months** from the date received by the county examiner of drivers.

_____ _____
Signature of Applicant Date

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:
(Must be filled in before the medical exam.)

Applicant Information

Applicant's Name (Last, First, Middle Initial)		Age
Driver's License #	Telephone #	

Physician's Report

How long have you treated this patient?

Date of last examination: (**Medical Report is valid for only 6-months.**)

A. Has the patient had loss of consciousness or alteration in awareness?

(Please do not answer yes for other neurological symptoms) Yes ☐ No ☐

1. ☐ Syncope ☐ Seizure ☐ Hypoglycemia ☐ Other (explain)

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 (explain) ☐ Frozen joint(s) ☐ Decreased mobility

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

☐ Other: _____
(For Visual issues, see Section E 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. For dementia: MMSE score _____ or MOCA score _____
Patient's family has expressed concerns about safe driving: Yes ☐ No ☐
Number of car accidents has patient had in past 2 years (including minor accidents) _____

3. How does it affect driving ability?

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

5. Modifying factors? Type of 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? Yes ☐ No ☐
If yes, explain type of treatment (Medications, Psychiatry, AA, etc.):

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. Prescribed Medications

1. What medications are the patient taking? How often? (Please attach additional pages as needed)

☐ Medication record provided as an attachment

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

_____

_____

_____

_____

_____

G. Summary

1. In your opinion is this person capable of safe driving?

☐ Yes (No road test needed) ☐ Yes (But recommend a road test) ☐ No (Not safe to drive)

☐ Other (Please explain):

2. Do you recommend the maximum licensing period?

☐ Yes (see below for the maximum 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 72-79	Age 80+
	1 to 4 years	4 years	8 years	4 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 the county Examiner of Drivers to determine the eligibility of the applicant to be licensed in the State of Hawaii.

Medical Examiner's Name (print clearly)	Date of Examination **(Must be rec'd within 6 mo.)**	Office Telephone #
Signature of licensed medical examiner	Medical License #	Specialty

Print Form