Driver
Medical Evaluation

P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-1631 • DriverLicense@mt.gov • dojmt.gov

This form allows commercial drivers to self-certify you are an Interstate Excepted or Intrastate Excepted status.

Legal First Name	Legal Middle Name	Legal Last Name	Driver License Number	
Mailing Address		City	State	Zip Code
Email Address		Phone Number		Date of Birth

A. Introduction to Physician Provider

The Motor Vehicle Division records indicate your patient may have a condition that could affect the safe operation of a motor vehicle.

Your experience and knowledge of the patient's condition, results of medical examinations and treatment plans, will be of great value in assisting the department to determine a proper licensing decision. A physician reporting in good faith is immune from liability, civil or criminal penalties under Montana law § 37-2-311, MCA and § 37-2-312, MCA. The department has sole responsibility for any decision regarding the patient's driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

PLEASE ANSWER ALL APPLICABLE QUESTIONS. Leave blank any items not covered in your examination. If the case is unique, additional comments may be helpful. Attach a separate sheet if necessary. **For proper identification, have the patient sign the release authorization in your presence.**

B. Referral Description

We are seeking information about any condition which may interfere with the safe operation of a motor vehicle. The patient presented with:

_____

_____

RELEASE OF INFORMATION BY PATIENT – SIGN IN PRESENCE OF PHYSICIAN/PROVIDER

I authorize my physician/provider or hospital to answer any questions from the Motor Vehicle Division, or its employees relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana.

I authorize the Motor Vehicle Division to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

Signed: X _____ Date: _____

C. History

How Long has this person been your patient? _____ Date of last examination? _____

Applying for ☐ Class D (Regular Driver) ☐ Intrastate CDL (Montana Only) ☐ Interstate CDL

D. Medications

List any medication currently prescribed: _____

_____

_____

Is your patient adhering to the medical regimen? ☐ Yes ☐ No If no, explain: _____

Would the side effects from the prescribed medication interfere with the safe operation of a motor vehicle? ☐ Yes ☐ No

If yes, describe: _____

Is your patient under a controlled medical program? ☐ Yes ☐ No

Indicate how long control has been maintained (i.e. 3 months, 6 years, etc.)? Months: _____ Years: _____

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E. Lapse of Consciousness or Control Disorder

Does your patient exhibit any disease or disorder including epilepsy, narcolepsy, diabetes, cerebral vascular diseases, or any other impairment that may cause loss of consciousness or control of motor functions at any time? ☐ Yes ☐ No

Date of last episode _____ Is the condition stabilized? ☐ Yes ☐ No

Describe Condition(s): _____

F. Impairments

Does your patient have any impairments? (Mark all that apply)

- ☐ Impaired motor function
- ☐ Reaction, or impairment due to change in medication or dosage
- ☐ Neurological or neuromuscular disease
- ☐ Diminished concentration
- ☐ Diminished judgement
- ☐ Memory Loss
- ☐ Alzheimer's disease
- ☐ Confusion
- ☐ Other: _____

Describe Condition: _____

G. Diagnosis

_____

_____

_____

Is the condition: ☐ Improving ☐ Stable ☐ Worsening or deteriorating ☐ Subject to change

H. Physical and Mental Capability

Is your patient physically and mentally capable of safely operating a motor vehicle, in your opinion? ☐ Yes ☐ No

If **NO**, describe: _____

I. Adaptive Equipment

Do you recommend any adaptive equipment for your patient? ☐ Yes ☐ No If **YES**, mark all that apply

- ☐ Steering Knob
- ☐ Pedal Extension
- ☐ Manual Brake
- ☐ Automatic Transmission
- ☐ Mechanical Turn Indicator
- ☐ Hand Controls
- ☐ Other: _____

Describe Condition: _____

Note: The Motor Vehicle Division may not be able to add recommended restrictions in certain situations.

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J. Driving Restrictions

Do you recommend any driving restrictions for your patient? ☐ Yes ☐ No

If **YES**, mark all that apply

- ☐ Corrective Lenses
- ☐ Daylight Hours Only
- ☐ Left Outside Mirror (for hearing impaired)
- ☐ Low Speed Vehicle Only
- ☐ No Interstate Driving
- ☐ No Inclement Weather
- ☐ Oxygen While Driving
- ☐ Restricted Area: _____
- ☐ Restricted Speeds (45 mph secondary roads, 55 mph interstate)

Describe why driving restrictions are needed: _____

K. Periodic Driving Evaluations

Do you recommend the Motor Vehicle Division conduct periodic driving evaluations of your patient? ☐ Yes ☐ No

If **YES**, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ _____ years

L. Periodic Knowledge Testing

Do you recommend the Motor Vehicle Division conduct periodic knowledge testing of your patient? ☐ Yes ☐ No

If **YES**, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ _____ years

M. Periodic Medical Report

Do you recommend your patient submit a periodic Medical Evaluation to the Motor Vehicle Division to monitor changes? ☐ Yes ☐ No

If **YES**, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ years

Print Name:	Type of Medical Specialty:	Medical License Number:	
Address:	City:	State:	Zip Code:
Email Address:		Phone Number:	
Signature:		Date:	

Please return completed form by fax, email, or mail form to:

Motor Vehicle Division
Attn: Medical Unit
PO Box 201430
Helena, MT 59620-1430