MC-028 (5/2010)
MICHIGAN STATE POLICE
Traffic Safety Division

PHYSICIAN'S STATEMENT OF EXAMINATION

INSTRUCTIONS FOR DRIVER/APPLICANT
Please have your treating physician complete this statement. It is the applicant's responsibility to mail the completed form to the address below. Failure to have this form completed and returned may result in your medical waiver application being delayed until we have received and evaluated this statement.

Mail completed application and other required items to:

Michigan Department of State Police
Traffic Safety Division
Medical Waiver Unit
P.O. Box 30634
Lansing, Michigan 48909-0634

RELEASE OF INFORMATION

(Application cannot be processed without signature)

To be completed by Intrastate Medical Waiver applicant or applicant's representative. Please Print.

Applicant's Name (Last, First, Middle)		Date of Birth	Driver License Number
Street Address	City	State	Zip
Address Line 2		Daytime Phone	
I hereby authorize and request that information regarding my medical condition be released to the Michigan Department of State Police.			
Applicant's Signature		Date	

INSTRUCTIONS FOR PHYSICIAN
Please fill out all section(s) indicated or that in your professional opinion are pertinent to this applicant to help in our determination for a medical waiver. The Department of State Police is asking for assistance in the determination of this patient's physical and mental condition as it may relate to their continued safe operation of a commercial motor vehicle.

PLEASE TYPE OR PRINT YOUR ANSWERS.

- ☐ **(Section A) NEUROLOGICAL OR NEUROMUSCULAR DISEASES (Page 2)**
- ☐ **(Section B) OTHER MEDICAL DISORDERS, GENERAL MEDICAL CONDITIONS (Pages 3-4)**
- ☐ **(Section C) DRUGS AND ALCOHOL (Page 4)**
- ☐ **(Section D) PSYCHOLOGICAL EVALUATION (Page 5)**
- ☒ **(Section E) COMMENTS SECTION (Must be completed for All Applicants) (Page 6)**
- ☒ **(Section F) PHYSICIAN'S CERTIFICATION (Must be completed for All Applicants) (Page 6)**

NOTE: The Physician must complete the Comments Section (Section E) and the Physician's Certification (Section F).

AUTHORITY:	1963 PA 181
COMPLIANCE:	Mandatory. A state civil infraction penalty if driver operates without medical certification or waiver.

SECTION A: NEUROLOGICAL AND NEUROMUSCULAR DISEASES

The physician must fill out the parts below that are pertinent to the patient.

Applicant's Name	Application Date

I. Disease Causing Loss or Impairment of Consiousness or Confusion

- ☐ Epilepsy - Type: _____
- ☐ Narcolepsy
- ☐ Cereberal Vascular Disease/Insufficiency (complete Atherosclerosis/Heart Disease Section on pages 3-4)
- ☐ Vasovagal Syncope
- ☐ Other (open & closed head injuries, craniotomies, etc.) Please Explain: _____

Related Information:

Age of onset of illness	Date of Last Seizure or Episode	Frequency of Seizure or Episode

Has the patient reported a seizure or epoisode within the last 12 months?	Yes ☐	No ☐
Did the patient experience a loss or impairment of level of consiousness?	Yes ☐	No ☐
Has the patient reported a seizure or epoisode within the last 24 months?	Yes ☐	No ☐

Current Medication and Dosage	Start Date	Medication	Dosage
	Start Date	Medication	Dosage

Is there a **reasonable** medical certainty that the last seizure or episode resulted from a medically supervised change in medication or dosage?	Yes ☐	No ☐
If yes, please explain.		
Has patient had any adverse reaction to treatment or medication?	Yes ☐	No ☐
If yes, please explain.		

II. Other Limiting or Progressive Neurological or Neuromuscular Diseases

Cerebral Palsy, Paraplegia, Muscular Dystrophy, Parkinsonism, Multiple Sclerosis, etc.

Specific Diagnosis	Age of patient at onset of disease

Please describe the patient's neuromuscular condition, including changes that are likely in the future:

Current Medication and Dosage	Start Date	Medication	Dosage
	Start Date	Medication	Dosage

Is the patient's disease/condition adequately controlled with medication?	Yes ☐	No ☐
Do you believe the patient is capable of safely operating a commercial motor vehicle based on the current medical condition, including medications?	Yes ☐	No ☐
If no, please explain.		

III. Diseases Affecting Cognition

☐ Dementia or Senility ☐ Poor Memory ☐ Sleep Apnea ☐ Impairment of Judgement ☐ Other

Specific Diagnosis

Please describe the severity of the illness, treatment, and prognosis:

Current Medication and Dosage	Start Date	Medication	Dosage
	Start Date	Medication	Dosage

Do you believe the patient is capable of safely operating a commercial motor vehicle based on the current medical condition, including medications?	Yes ☐	No ☐
If no, please explain:		

SECTION B: OTHER MEDICAL DISORDERS, GENERAL MEDICAL CONDITIONS

The physician must fill out the parts below that are pertinent to the patient.

Applicant's Name	Application Date

I. Diabetes and Other Metabolic Disorders

Diabetes Type 1 ☐ Type 2 ☐	Age of patient at onset of illness		
Insulin Injections? Yes ☐ No ☐	Start Date	Strength	Frequency
Patient follows diet instructions? Yes ☐ No ☐	Patient is responsible in the management of the disease? Yes ☐ No ☐		
Comments			
Reaction episodes (**Those causing loss or impairment of level of consiousness)**			
Hypoglycemic Yes ☐ No ☐	Frequency		
Hyperglycemic Yes ☐ No ☐	Frequency		
Renal Desease Yes ☐ No ☐	BUN	Creatine	
If yes to Hypoglycemic or Hyperglycemic, was the episode unusual in nature for this patient? Yes ☐ No ☐	Date of last episode		
If yes, please explain.			
Symptoms	Impairment of level of consiousness Yes ☐ No ☐	Loss of judgement Yes ☐ No ☐	
	Loss of motor skills Yes ☐ No ☐	Difficulty recalling the episode Yes ☐ No ☐	
If any response was answered yes, please explain.			
Has the patient's condition stabilized? Yes ☐ No ☐			
Is there reasonable medical certainty that the last episode resulted from medically supervised change in medication or dosage? Yes ☐ No ☐			
If yes, please explain.			
Date of last blood glucose test	Blood glucose level	Frequency of test	
Date of last A1C test	A1C	Frequency of test	
Vision Problems Yes ☐ No ☐	If yes, please describe.		

II. Atherosclerosis/Heart Disease

Diagnosis				
Peripheral Vascular Disease	Yes ☐	No ☐	Location of disease	
Cerebral vascular disease	Yes ☐	No ☐	Comments	
Coronary vascular disease	Yes ☐	No ☐	Comments	
Angina	Yes ☐	No ☐	Frequency	Date of onset
During Driving	Yes ☐	No ☐	Comments	
Dyspnea	Yes ☐	No ☐	Comments	
Syncope (near or confusion)	Yes ☐	No ☐	Frequency	Date of last syncope
Arrhythmia	Yes ☐	No ☐	Frequency	Type
Infarction	Yes ☐	No ☐	Dates	
Congestive Failure	Yes ☐	No ☐	Ever: Yes ☐ No ☐	
Defibrillator	Yes ☐	No ☐	Comments	
Pacemaker	Yes ☐	No ☐	Comments	
Hypertension	Yes ☐	No ☐	Blood Pressure	Heart Rate

Applicant's Name	Application Date

OTHER MEDICAL DISORDERS, GENERAL MEDICAL CONDITIONS (Continued)

Current Medication and Dosage	Start Date	Medication	Dosage
	Start Date	Medication	Dosage

Has patient had any adverse reaction to medication or treatment for the condition?	Yes ☐	No ☐
If yes, please explain.		
Has the patient reached maximum recovery period?	Yes ☐	No ☐
If no, please explain.	If no, expected date.	
Is the above condition medically treatable?	Yes ☐	No ☐
Please elaborate		
How will this medical condition affect the patient's ability to safely operate a commercial motor vehicle?		

III. General Medical Conditions (Not discussed in other sections)

Diagnosis			
Current Medication and Dosage	Start Date	Medication	Dosage
	Start Date	Medication	Dosage

Has patient had any adverse or other reaction to treatment or medication?	Yes ☐	No ☐
If yes, please explain.		
Do you recommend driving restrictions?	Yes ☐	No ☐
If yes, please explain.		

SECTION C: DRUGS AND ALCOHOL

The physician must fill out the parts below that are pertinent to the patient.

Does the patient have any clinical evidence or do you have personal knowledge of patient's addiction or habituation to illegal drugs, alcohol, or prescriptions?	Yes ☐	No ☐
If yes, indicate drug and duration of addiction.		
Has patient attended residential treatment or hospitalization for condition?	Yes ☐	No ☐
If yes, indicate dates of treatment or hospitalization.		
Is patient currently under therapy?	Yes ☐	No ☐
If yes, where?	Frequency and duration of therapy	
Is there evidence of physical complications from alcohol, illegal, or prescription medication drug abuse?	Yes ☐	No ☐
If yes, please explain.		
Has patient been advised to abstain from addictive substance?	Yes ☐	No ☐
Has patient followed your recommendations for treatment or therapy?	Yes ☐	No ☐
Has patient been prescribed antabuse?	Yes ☐	No ☐
Is patient's antabuse monitored?	Yes ☐	No ☐
If yes, explain the frequency of monitoring and by whom.		
Has period of abstinence or control been established?	Yes ☐	No ☐
If yes, state the date of last consumption/use.		
What is your professional prognosis for this patient's condition?		

SECTION D: PSYCHOLOGICAL EVALUATION

The physician must fill out the parts below that are pertinent to the patient.

Applicant's Name	Application Date

Diagnosis of psychiatric illness

Approximate date of illness onset

Which of the following symptoms are present? (Please check all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Euphoria
- ☐ Poorly Controlled Anger
- ☐ Bizarre Behavior
- ☐ Other
- ☐ Dementia or Senility
- ☐ Paranoid Ideation
- ☐ Suicidal Impulses
- ☐ Homicidal Impulses
- ☐ Insomnia
- ☐ Delusions
- ☐ Hallucinations
- ☐ Impairment of Judgement
- ☐ Poor Memory
- ☐ Mental Retardation

If other, please specify

Please expand on any of the above, including approximate duration of illness, severity of illness, treatment, and prognosis.

Current Medication and Dosage	Start Date	Medication	Dosage
	Start Date	Medication	Dosage

Has patient had any adverse reaction to medication, treatment or therapy? Yes ☐ No ☐

If yes, please explain.

Does medication make patient drowsy? Yes ☐ No ☐

Is patient capable of safely operating a commercial motor vehicle while taking the above prescribed medication(s)? Yes ☐ No ☐

If no, please explain.

Has patient been hospitalized for the disorder? Yes ☐ No ☐

Is yes, please indicate when, where, and for how long.

Frequency of therapy

Does patient follow your medical and psychiatric recommendations? Yes ☐ No ☐

If no, please explain.

Do you believe the patient is capable of safely operating a commercial motor vehicle based on patient's current medical condition, including medications? Yes ☐ No ☐

If no, please explain.

Do you recommend any driving restrictions based on medication or current medical condition of this patient? Yes ☐ No ☐

Please explain.

Other comments or recommended driving restrictions based on psychological condition of this patient

SECTION E: COMMENTS

The physician **must** fill out the information below before processing will occur.

Applicant's Name	Application Date

How long has patient been under your treatment?		
Has patient followed your medical recommendations?	Yes ☐	No ☐
Was patient examined on this date?	Yes ☐	No ☐
If no, specify the date of most recent medical examination		
Does patient take medication as prescribed?	Yes ☐	No ☐
Please explain any no answers to the above questions		
Was patient referred to you by another doctor?	Yes ☐	No ☐
If yes, please indicate the name and address of referring doctor		
Have you referred patient to another medical specialist for diagnosis or treatment?	Yes ☐	No ☐
If yes, please indicate the name and address of medical specialist patient was referred		
What were the results of this consultation?		
Any adverse reactions to medication, treatment or therapy?	Yes ☐	No ☐
If yes, please explain		
Does medication make patient drowsy?	Yes ☐	No ☐
Is patient capable of safely operating a commercial motor vehicle while taking the above medication(s) or treatment(s)?	Yes ☐	No ☐
If no, please explain		
Has the patient ever had occupational or physical therapy for the condition in question?	Yes ☐	No ☐
Do you recommend that the department request a statement of your patient's psychological condition?	Yes ☐	No ☐
Do you recommend that the department request a statement of your patient's visual acuity?	Yes ☐	No ☐
Should the department require periodic medical evaluation to monitor changes in patient's condition that may affect driving ability?	Yes ☐	No ☐
If yes, how often?		
Do you recommend any driving restrictions (times, trip lengths, trip radius, adaptive equipment etc.)?	Yes ☐	No ☐
If yes, please specify.		
Do you recommend the Employer conduct an on-the-road driving preformance evaluation for this driver at this time?	Yes ☐	No ☐
If yes, how often?		
Include any additional information you feel will help in assessing your patient's ability to safely operate a commercial motor vehicle		

SECTION F: PHYSICIAN'S CERTIFICATION

The physician **must** fill out the information below before processing will occur.

As of this date, I certify that the statements contained in this statement of examination are true to the best of my knowledge and belief.			
Name (Print or Type)	☐ M.D. ☐ D.O.	Telephone Number	
Address	City	State	Zip Code
Professional License Number	Type of Practice or Medical Specialty		
Physician's Signature		Date	