

Michigan Department of State
Business Licensing Section
Lansing, MI 48918

Medical Examination Report

Check Reason(s): _____ Driver Education Instructor Number _____
_____ Driving Skills Test Examiner Number _____

INSTRUCTIONS FOR APPLICANT: A Medical Examination Report completed by a physician, a physician's assistant, or a certified nurse practitioner licensed to practice in this state or the applicant's state of residence must be submitted to the Department of State and be updated every two years. The medical information provided **may** be used to request an assessment of your driving privilege. Please complete the 'Release of Information' below before presenting the form to a physician, physician's assistant, or certified nurse practitioner.

Medical Examination Reports may not be more than 90 days old when submitted.

RELEASE OF INFORMATION	I authorize and request information regarding my physical condition be released to the Department of State. I understand that the information provided may prompt an evaluation of my ability to operate a motor vehicle safely.			
	_____ Name (Print)	_____ Date of Birth	_____ Signature	_____ Date

INSTRUCTIONS FOR PHYSICIAN, PHYSICIAN'S ASSISTANT, OR CERTIFIED NURSE PRACTITIONER: The patient for whom you are completing this report has submitted an application to the Department of State for licensure as a driver education instructor. Your answers, and any additional information you feel is pertinent, will aid this office in determining whether the applicant is physically able to operate a motor vehicle safely as well as to instruct others to safely operate a motor vehicle.

A. Does the above applicant have any of the following (check the ones applicable):

- | | |
|--|---|
| <input type="checkbox"/> Disease causing impairment, loss of consciousness, or confusion | <input type="checkbox"/> Limitation of movement or use (or loss) of a foot, leg, or arm |
| <input type="checkbox"/> Limiting or progressive neurological or neuromuscular disease | <input type="checkbox"/> Respiratory dysfunction |
| <input type="checkbox"/> Diabetes or other metabolic disorder | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Atherosclerosis/heart disease | <input type="checkbox"/> Depression |
| | <input type="checkbox"/> Poorly Controlled Anger |

B. If any of the above boxes are checked, in your opinion would the condition interfere with safe driving or providing driving instruction to others? Yes No

If yes, please explain: _____

C. Does the patient have any clinical evidence or do you have personal knowledge of your patient's addictions to or the habitual use of drugs or alcohol? Yes No

If yes, indicate the addiction and the duration of the addiction _____
Is the patient currently under treatment for the addiction? Yes No

I certify that I am a physician, physician's assistant, or a certified nurse practitioner, and the statements contained in this report are true to the best of my knowledge and belief. I also certify that the applicant is medically qualified to safely operate a motor vehicle and to train others to safely operate a motor vehicle.

Name (Print) _____ Signature _____ Date _____

Address (Street, City, State, Zip) _____

Phone _____ License Number _____ Type of Practice _____