Clear Form

Driver Education Instructor

MEDICAL EXAMINATION REPORT

Michigan Department of State ● Driver Education Section ● 430 W. Allegan St. ● Lansing, MI 48918

Michigan Department of State
DES-N05 10/2023

PART A – RELEASE OF INFORMATION	Application for: ☐ Driver Education Instructor		
Name of Applicant (Last, First, Middle):	Instructor's Certificate Number:	Date of Birth:	
Street Address:	City:	State:	Zip Code:

I hereby authorize and request that information regarding my medical condition be released to the Michigan Department of State and understand that the information provided may be used to request an assessment of my driving privilege.

Signature of Applicant:	Date Signed:

INSTRUCTIONS FOR PHYSICIAN

The Michigan Department of State requests your professional assistance to determine the physical and mental condition of the above patient. Your response to these questions and any other pertinent information will help the MDOS assess the patient's ability to safely operate a motor vehicle and to train others to operate a motor vehicle. Confidential information may be mailed directly to the MDOS at the address shown above.

1. DEPIA MCL 256.637 (3)(j) Submits a certified medical examination report that is not older than 90 days and that is prepared by a **physician**, a **physician's assistant,** or a **certified nurse practitioner** licensed to practice in this state or in the applicant's state of residence. The report shall include a statement by the person that certified the report that the applicant is medically qualified to operate a motor vehicle and to train others to operate a motor vehicle.

PART B – HEALTH QUESTIONS	YES	NO
1. In the last twelve months has the patient had a medical condition which affected their ability to drive?	☐	☐
If "yes", please explain:		
2. In the last twelve months has the patient had a fainting spell, blackout, seizure or other loss of consciousness?	☐	☐
If "yes", please explain:		
3. Does the patient have any visual impairments that would interfere with their ability to drive a motor vehicle safely?	☐	☐
4. Has the patient had a heart attack, angina, coronary insufficiency, thrombosis, stroke, other heart problem, or cardiovascular disease?	☐	☐
If "yes", has patient had labored breathing, fainting, collapse, congestive heart failure, or other symptoms in the last two (2) years?	☐	☐
5. Has the patient been diagnosed with a respiratory condition, such as emphysema, chronic asthma, or tuberculosis?	☐	☐
If "yes", is patient's respiratory condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
6. Has the patient ever been diagnosed with rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease?	☐	☐
If "yes", is the condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
7. Does the patient have clinical evidence or do you have personal knowledge of misuse or abuse of prescription drugs, illicit drugs or alcohol?	☐	☐
If "yes", please explain:		
8. Does the patient have any diagnosed mental, nervous, organic or functional disease, or psychiatric disorder?	☐	☐
If "yes", is the condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐

PART C – MEDICAL EXAMINER'S CERTIFICATION

To be completed by authorized physician.

- I hereby certify that I am a physician, physician's assistant, or a certified nurse practitioner licensed to practice in this state or in the applicant's state of residence, and the statements contained in this report are true to the best of my knowledge and belief, and affirm that I have examined the applicant for any and all physical impairments or conditions that would preclude them from operating a motor vehicle and to train others to operate a motor vehicle in accordance to MCL 256.637(3)(j) and that the patient:

☐ **Has no** physical impairment or condition that would preclude them from operating a motor vehicle and to train others to operate a motor vehicle in accordance with MCL 256.637(3)(j).

☐ **Has a** physical impairment or condition that would preclude or limit them from operating a motor vehicle and to train others to operate a motor vehicle in accordance with MCL 256.637(3)(j).

- ☐ Preclude the applicant from: **TRAINING OTHERS TO OPERATE A MOTOR VEHICLE** (NO Behind-the-Wheel Instruction.).
- ☐ Limit the applicant to: **TRAIN OTHERS TO OPERATE A MOTOR VEHICLE ONLY DURING THE DAYTIME HOURS.**

Medical Examiner's Name:	Date of Medical Examination:	Office Phone #:
Office Address:		License Number:
Medical Examiner's Signature:		Date Report Completed: