MEDICAL FORM
P-142M Rev. 04-22

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
60 STATE STREET, WETHERSFIELD, CT 06161-1013
DRIVER SERVICES DIVISION
telephone: (860)263-5723 email: dmv.suspension@ct.gov

☐ Department of Aging and Disability Services (ADS) / Driver Training Program (DTP) Referral

INSTRUCTIONS

- **Patient:** Complete section (A).
- **Medical examiner(s) (licensed physician, PA or APRN)**: Complete section (B) and all subsections of section (C) based on the results of a personal examination conducted within ninety (90) days of the completion of this report. Attach other information as necessary, including any technical reports or test results.

Submission of this report to the Department of Motor Vehicles (DMV) is authorized pursuant to Section 14-46 of the Connecticut General Statutes, and no civil action may be brought against any person who, in good faith, provides a report to the DMV. Pursuant to Sections 14-46b and 14-46c of the Connecticut General Statutes, medical reports may be referred to the DMV's Medical Advisory Board (MAB) for review. The MAB may request additional medical information in determining the patient's ability to safely operate a motor vehicle. Based upon all available information, the DMV will make a final decision concerning the patient's ability, or privilege, to hold an operator's license.

Section (A): **Patient Information**

NAME *(Last, First, Middle)*	**DATE OF BIRTH**	**OPERATOR'S LICENSE NUMBER**

MAILING ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*	**PATIENT'S PHONE NUMBER**

Commercial Driver's License (CDL) Holder or Applicant (CLP)? ☐ **YES** ☐ **NO**

Passenger Endorsement (PPE) Holder or Applicant? ☐ **YES** ☐ **NO**

I hereby understand that my medical examiner will conduct a medical examination to determine my fitness to operate a motor vehicle safely, and that (s)he may submit copies of my medical records to the DMV and ADS.

SIGNATURE OF DRIVER / PATIENT	**DATE**	**EMAIL ADDRESS**
X		

PATIENT AUTHORIZATION: *Complete this section only if you authorize the DMV's Driver Services Division to discuss your medical case with the individual(s) identified below.*

(Please Print)

I, _____ GIVE PERMISSION TO THE DEPARTMENT OF MOTOR VEHICLES' DRIVER SERVICES DIVISION TO DISCUSS MY MEDICAL CASE WITH THE INDIVIDUAL(S) NAMED BELOW:

1. _____ 2. _____

SIGNATURE OF DRIVER / PATIENT	**DATE**

BELOW TO BE COMPLETED BY MEDICAL EXAMINER (Sections B and C)

If medical reporting is required, you must indicate the term of reporting (how often a report should be filed with the DMV) in the appropriate condition-specific subsection of section (C). This only pertains to medical reports to be filed with the DMV and not to routinely scheduled office visits for the patient. If the patient has "no known condition" in a specific subsection, the box indicating as such must be checked, and the medical examiner must provide initials and a date next to the checked box.

Section (B): **Clinical Information and Safety Implications**

The person named above is NOT medically qualified to safely operate a motor vehicle due to the medical condition identified below. ☐

If this box is checked, the patient's license or license privilege will be withdrawn. The medical examiner must certify and sign below (bottom of page), and the remainder of the form must be completed for the relevant condition which would cause the patient's license or license privilege to be withdrawn.

REGARDING: *(DMV use only)* _____

***If applicable*, has the incident dated _____ been discussed fully with the patient?** ☐ **YES** ☐ **NO**

Indicate any present conditions that may affect this patient's fitness to drive safely:

Do you believe this person should be referred to another physician/specialist? ☐ **YES*** ☐ **NO**

***If *YES*, please indicate specialty:** _____

Do you believe this person should be required to complete a DMV road test to determine driving ability? ☐ **YES** ☐ **NO**

MEDICAL REPORTING GENERAL

Considering this patient's condition, should periodic reports be submitted to the DMV to ensure that there have been no changes in the patient's fitness to safely operate a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, for which condition(s):** _____ ***How often should a report be filed? **Every** _____ **months for** _____ **year(s).**

Pursuant to Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear, under penalty of deliberate false statement, that the above information, and any attachment hereto, is true and correct. I also certify that I have personally examined this patient within the ninety (90) days preceding the completion of this report.

MEDICAL EXAMINER'S SIGNATURE	**LICENSE NUMBER**	**TELEPHONE NUMBER**	**EXAMINATION DATE**
X			
MEDICAL EXAMINER'S NAME *(Please Print)*	**SPECIALTY**	**DATE SIGNED**	

LICENSE NUMBER: _____

Section (C): Condition-Specific Information *(Continued on Page 3)*

CARDIOLOGY

If the patient has no known cardiac condition, the box below must be checked, and the medical examiner must provide initials and a date next to the checked box.

The patient has no known cardiac condition. ☐ _____ Medical Examiner Initials and Date

If present, name(s) of specific cardiac condition(s) : _____

Has the patient suffered lost or altered consciousness/awareness? ☐ **YES*** ☐ **NO**

*If *YES*, state episodes of lost or altered consciousness/awareness within the past six months *(begin with the most recent date)*:

DATE	TYPE/CAUSE	DATE	TYPE/CAUSE

Considering this patient's condition, do you believe this person may safely operate a motor vehicle? ☐ **YES** ☐ **NO**

If a cardiac condition is present, is the patient following the physician's prescribed protocol? ☐ **YES** ☐ **NO***
(Inclusive of medication(s))

***If *NO*, does it affect the patient's ability to safely operate a motor vehicle?** ☐ **YES** ☐ **NO**

MEDICAL REPORTING CARDIOLOGY

Considering this patient's condition, should periodic reports be submitted to the DMV to ensure that there have been no changes in the patient's fitness to safely operate a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, How often should a report be filed? **Every** _____ **months for** _____ **year(s).**

Pursuant to Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear, under penalty of deliberate false statement, that the above information, and any attachment hereto, is true and correct. I also certify that I have personally examined this patient within the ninety (90) days preceding the completion of this report.

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X			
MEDICAL EXAMINER'S NAME *(Please Print)*	**SPECIALTY**	**DATE SIGNED**	

DIABETES / METABOLIC SYNDROME

If the patient has no known diabetic/metabolic condition, the box below must be checked, and the medical examiner must provide initials and a date next to the checked box.

The patient has no known diabetic/metabolic condition. ☐ _____ Medical Examiner Initials and Date

If diabetes/metabolic condition is present, has the patient suffered lost or altered consciousness/awareness? ☐ **YES*** ☐ **NO**

*If *YES*, state episodes of lost or altered consciousness/awareness within the past six months *(begin with the most recent date)*:

DATE	TYPE/CAUSE	DATE	TYPE/CAUSE

Considering this patient's condition, do you believe this person may safely operate a motor vehicle? ☐ **YES** ☐ **NO**

Is there significant neuropathy? ☐ **YES*** ☐ **NO** .....***If YES, does it affect motor vehicle operation?** ☐ **YES** ☐ **NO**

Has the patient suffered retinopathy to the point of vision loss? ☐ **YES*** ☐ **NO** ..... ***If YES, form P-142OP must be submitted.**

If a diabetic/metabolic condition is present, is the patient following the physician's prescribed protocol? ☐ **YES** ☐ **NO***
(Inclusive of medication(s))

***If *NO*, does it affect the patient's ability to safely operate a motor vehicle?** ☐ **YES** ☐ **NO**

MEDICAL REPORTING DIABETES/METABOLIC

Considering this patient's condition, should periodic reports be submitted to the DMV to ensure that there have been no changes in the patient's fitness to safely operate a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, How often should a report be filed? **Every** _____ **months for** _____ **year(s).**

Pursuant to Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear, under penalty of deliberate false statement, that the above information, and any attachment hereto, is true and correct. I also certify that I have personally examined this patient within the ninety (90) days preceding the completion of this report.

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LICENSE NUMBER: _____

Section (C): **Condition-Specific Information** *(Continued on Page 4)*

NEUROLOGY

If the patient has no known neurological condition, the box below must be checked, and the medical examiner must provide initials and a date next to the checked box.

The patient has no known neurological condition. ☐ _____ Medical Examiner Initials and Date

If present, name(s) of specific neurological condition(s) : _____

State episodes of lost or altered consciousness/awareness within the past six months *(begin with the most recent date)*:

DATE	TYPE/CAUSE	DATE	TYPE/CAUSE

Considering this patient's condition, do you believe this person may safely operate a motor vehicle? ☐ **YES** ☐ **NO**

If a neurological condition is present, is the patient following the physician's prescribed protocol? ☐ **YES** ☐ **NO***
(Inclusive of medication(s))

***If *NO*, does it affect the patient's ability to safely operate a motor vehicle?** ☐ **YES** ☐ **NO**

MEDICAL REPORTING NEUROLOGY

Considering this patient's condition, should periodic reports be submitted to the DMV to ensure that there have been no changes in the patient's fitness to safely operate a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, How often should a report be filed? **Every** _____ **months for** _____ **year(s).**

Pursuant to Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear, under penalty of deliberate false statement, that the above information, and any attachment hereto, is true and correct. I also certify that I have personally examined this patient within the ninety (90) days preceding the completion of this report.

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X			
MEDICAL EXAMINER'S NAME *(Please Print)*	**SPECIALTY**	**DATE SIGNED**	

ORTHOPEDIC

If the patient has no known orthopedic condition, the box below must be checked, and the medical examiner must provide initials and a date next to the checked box.

The patient has no known orthopedic condition. ☐ _____ Medical Examiner Initials and Date

☐ **ADS / DTP Referral**

☐ **Due to this patient's medical condition, (s)he is NOT fit to safely operate a motor vehicle PRIOR to completing the DTP through ADS.**

If present, name(s) of specific orthopedic condition(s): _____

Is this a progressive illness? ☐ **YES*** ☐ **NO**

***If *YES*, does it affect the patient's ability to safely operate a motor vehicle?** ☐ **YES** ☐ **NO**

Is this patient's movement limited? ☐ **YES*** ☐ **NO**

***If *YES*, does it affect the patient's ability to safely operate a motor vehicle?** ☐ **YES** ☐ **NO**

Are there splints or appliances that should be worn while patient is operating a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, specify: _____

SPECIAL EQUIPMENT/ LICENSE RESTRICTIONS

Pursuant to Section 14-36a of the Connecticut General Statutes, and Section 14-36a-2 of the Regulations of Connecticut State Agencies, the patient may operate a motor vehicle, but only with the following restrictions:

☐ **MECHANICAL AID** *("C" Restriction)*
☐ **PROSTHETIC AID** *("D" Restriction)*
☐ **AUTOMATIC TRANSMISSION** *("E" Restriction)*

MEDICAL REPORTING ORTHOPEDIC

Considering this patient's condition, should periodic reports be submitted to the DMV to ensure that there have been no changes in the patient's fitness to safely operate a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, How often should a report be filed? **Every** _____ **months for** _____ **year(s).**

Pursuant to Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear, under penalty of deliberate false statement, that the above information, and any attachment hereto, is true and correct. I also certify that I have personally examined this patient within the ninety (90) days preceding the completion of this report.

MEDICAL EXAMINER'S SIGNATURE	LICENSE NUMBER	TELEPHONE NUMBER	EXAMINATION DATE
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LICENSE NUMBER: _____

Section (C): Condition-Specific Information

PSYCHIATRIC / SUBSTANCE ABUSE

If the patient has no known psychiatric/substance abuse condition, the box below must be checked, and the medical examiner must provide initials and a date next to the checked box.

The patient has no known psychiatric / substance abuse condition. ☐ _____ Medical Examiner Initials & Date

If present, name(s) of specific psychiatric/substance abuse condition(s): _____

Considering this patient's condition, do you believe this person may safely operate a motor vehicle? ☐ **YES** ☐ **NO**

Do you have reason to suspect the patient abuses alcohol, medications, or illicit drugs? ☐ **YES**** ☐ **NO**

****If *YES*, does this prevent the patient from operating a motor vehicle safely?** ☐ **YES** ☐ **NO**

Does this patient suffer from convulsive seizures? ☐ **YES*** ☐ **NO**

*If *YES*, state episodes within the past six months *(begin with the most recent date)*:

DATE	TYPE/CAUSE	DATE	TYPE/CAUSE

List any known medication(s) that may impact the patient's ability to safely operate a motor vehicle:

MEDICAL REPORTING PSYCHIATRIC/SUBSTANCE ABUSE

Considering this patient's condition, should periodic reports be submitted to the DMV to ensure that there have been no changes in the patient's fitness to safely operate a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, How often should a report be filed? **Every** _____ **months for** _____ **year(s).**

Pursuant to Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear, under penalty of deliberate false statement, that the above information, and any attachment hereto, is true and correct. I also certify that I have personally examined this patient within the ninety (90) days preceding the completion of this report.

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RESPIRATORY / SLEEP DISORDERS

If the patient has no known respiratory/sleep disorder, the box below must be checked, and the medical examiner must provide initials and a date next to the checked box.

The patient has no known respiratory / sleep disorder condition. ☐ _____ Medical Examiner Initials and Date

If present, name(s) of specific respiratory/sleep disorder condition(s): _____

Considering this patient's condition, do you believe this person may safely operate a motor vehicle? ☐ **YES** ☐ **NO**

If a respiratory/sleep disorder is present, is the patient following the physician's prescribed protocol? ☐ **YES** ☐ **NO***
(Inclusive of medication(s))

***If *NO*, does it affect the patient's ability to safely operate a motor vehicle?** ☐ **YES** ☐ **NO**

Has the patient suffered lost or altered consciousness/awareness? ☐ **YES** ☐ **NO**

*If *YES*, state episodes of lost or altered consciousness/awareness within the past six months *(begin with the most recent date)*:

DATE	TYPE/CAUSE	DATE	TYPE/CAUSE

Is this patient able to exhale 1000CC of air, in one continuous breath, during the operation of a motor vehicle that contains an ignition interlock device? ☐ **YES** ☐ **NO**

MEDICAL REPORTING RESPIRATORY/SLEEP

Considering this patient's condition, should periodic reports be submitted to the DMV to ensure that there have been no changes in the patient's fitness to safely operate a motor vehicle? ☐ **YES*** ☐ **NO**

If YES, How often should a report be filed? **Every** _____ **months for** _____ **year(s).**

Pursuant to Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear, under penalty of deliberate false statement, that the above information, and any attachment hereto, is true and correct. I also certify that I have personally examined this patient within the ninety (90) days preceding the completion of this report.

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