STATEMENT OF PHYSICIAN

NEBRASKA DEPARTMENT OF MOTOR VEHICLES
Once completed, please mail or fax to: PO Box 94726 Lincoln, NE 68509
FAX: 402-471-4020

NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE

(Applicant completes before exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my physical and psychological condition or history to the Department of Motor Vehicles, State of Nebraska.

Dated: _____ Signed: _____
(Applicant's Signature)

I hereby certify that I examined _____
(Applicant's Name)

of _____
(Street Address) (City) (Zip Code)

Date of Birth _____ License Number _____

To be completed by physician.

NEUROLOGICAL AND NEUROMUSCULAR DISEASES/CONDITION/INJURY:

I. CONDITION CAUSING CONFUSION, MEMORY LOSS OR LOSS OF CONSCIOUSNESS (Check)

1. ☐ Epilepsy-Type: _____ ☐ Narcolepsy
   ☐ Alcoholism *(complete Alcohol section below)* ☐ Cerebral Vascular Disease ☐ Other: _____
2. Frequency of seizures: _____ Date of last seizure: _____
   Reason for seizure _____
3. Frequency of loss of consciousness: _____ Date of last occurrence of loss of consciousness: _____
   Reason for loss of consciousness _____
4. Current medication and dosage: _____
   Have significant sedative or hypnotic effects occurred: ☐No ☐Yes ☐ Explain _____
5. Is this condition likely to worsen in the near future affecting the person's ability to operate a motor vehicle? ☐ No ☐ Yes
   Explain: _____

II. OTHER LIMITING OR PROGRESSIVE NEUROLOGIC OR NEUROMUSCULAR DISEASES (CEREBRAL PALSY, PARAPLEGIA, MUSCULAR DYSTROPHY, PARKINSONISM, STROKE, MULTIPLE SCLEROSIS, ETC.)

1. Specific diagnosis: _____ Age at onset: _____
2. Significant deterioration of neuromuscular function *(*strength, coordination*)* in the past year? _____
3. Describe the patient's neuromuscular functional limitations (strength, coordination, etc.): _____
   _____

CONDITION CAUSING VERTIGO OR MULTIPLE EPISODES OF DIZZINESS OR FAINTING:

1. Specific diagnosis: _____ Date of last occurrence: _____
2. Has condition been resolved? _____ Please explain: _____

DRUGS AND ALCOHOL EVALUATION:

1. Does the patient have or is there any objective evidence of addiction or habituation to drugs, tranquilizers or alcohol?
   ☐ No ☐ Yes If yes, type of drug and duration _____
2. Is patient currently under therapy? ☐ No ☐ Yes Explain: _____
3. Evidence of physical complications of alcohol or drugs (please state*)*: _____

PSYCHOLOGICAL EVALUATION:

1. Diagnosis of psychiatric illness: _____
   If any of the following symptoms are present please mark #1 or a #2
   1. Does not impair ability to operate a motor vehicle. 2. Impairs ability to operate a motor vehicle.

( ) Anxiety	( ) Visual or auditory	( ) Impairment of judgment
( ) Delusions	( ) Suicidal impulses or behavior	( ) Impairment of memory
( ) Euphoria	( ) Homicidal impulses or behavior	( ) Daytime sleepiness
( ) Hallucinations	( ) Paranoid ideation	( ) Other: _____
( ) Intermittent Explosive Episodes	( ) Depression	

To be completed by physician.

MEDICAL EVALUATION:

I. DIABETES

Type: ☐ Adult Onset ☐ Juvenile Onset Duration: _____

Insulin: ☐ No ☐ Yes Dose: _____

Oral hypoglycemic agents..... ☐ No ☐ Yes Dose: _____

Hypoglycemic reactions..... ☐ No ☐ Yes Frequency: _____

Date of last reaction:_____

Renal Disease..... ☐ No ☐ Yes BUN_____ Creatinine_____

Retinopathy..... ☐ No ☐ Yes

Should statement on vision be required?.. ☐ No ☐ Yes

II. ARTERIOSCLEROSIS

Peripheral vascular disease..... ☐ No ☐ Yes *

Cerebral vascular disease..... ☐ No ☐ Yes * *If yes, please complete Section III, HEART DISEASE.

Coronary vascular disease..... ☐ No ☐ Yes *

III. HEART DISEASE

Diagnosis: _____

Angina: ☐ No ☐ Yes Frequency: _____ Date of Onset:_____ During Driving: ☐ No ☐ Yes

Lightheadedness: ☐ No ☐ Yes Syncope: ☐ No ☐ Yes

Arrhythmia: ☐ No ☐ Yes Type: _____ Frequency: _____

Infarction: ☐ No ☐ Yes Number and dates: _____

Congestive failure at present: ☐ No ☐ Yes Ever: ☐ No ☐ Yes

Pacemaker: ☐ No ☐ Yes

Blood Pressure: _____ Heart Rate: _____

GENERAL STATEMENTS (THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY):

1 In your professional opinion, is this patient mentally capable of operating a motor vehicle safely?

☐ No ☐ Yes ☐ Only if appropriate tests as determined by the DMV are passed .

2. In your professional opinion, is this patient physically capable of operating a motor vehicle safely?

☐ No ☐ Yes ☐ Only if appropriate tests as determined by the DMV are passed .

3. Do you feel that this patient should have a medical evaluation for the purpose of operating a motor vehicle safely?

☐ No ☐ Yes ☐ If yes, how often? _____

If you wish to make additional comments, such as driving distance or day or night driving, or you have any recommended restrictions patient should have on license, please use space below or additional sheet(s) as necessary.

_____

If there are any other medical conditions not shown on this report that would affect the patient's ability to safely operate a motor vehicle, please describe as to frequency, severity, etc.:

_____

4. Based upon your examination, has the medical condition of this patient significantly worsened or another condition developed?

☐ No ☐ Yes If yes, please explain including how this affects the person's ability to safely operate a motor vehicle. _____

_____

For Commercial Motor Vehicle Operators Only: Was this condition in existence prior to July 30, 1996? ☐ No ☐ Yes

DATE OF EXAMINATION: _____ **(MUST BE COMPLETED—STATEMENT OF PHYSICIAN NOT VALID 90 DAYS FROM EXAMINATION DATE.)**

Name (Print or Type) _____ M.D. or D.O.

Type of Practice _____ Signature _____

Address _____

Phone Number:_____ Fax Number:_____