



INITIAL REPORTING FORM

PLEASE TYPE OR PRINT ALL INFORMATION IN BLUE OR BLACK INK

Bureau of Driver Licensing • P.O. Box 68682 • Harrisburg, PA 17106-8682 • (717) 787-9662
 Return this form to the address listed above, FAX to (717) 705-4415, or email to Medical@pa.gov.

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD

FOR OFFICIAL PENNDOT USE ONLY

PROVIDER: For more information relating to Medical Reporting, visit www.dmv.pa.gov and click on the Medical Reporting tab

SECTION A PATIENT INFORMATION

DRIVER'S LICENSE NO.		LAST NAME(S)			JR. ETC	FIRST NAME		
HEIGHT	SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER		SOCIAL SECURITY NUMBER
FEET	INCHES		MONTH	DAY	YEAR			
STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.					CITY	STATE	ZIP CODE	

DATE OF EXAMINATION: _____

How long have you been treating the patient? _____

SECTION B

DIAGNOSIS OF DISORDER OR DISABILITY: Please Check (✓) Appropriate Items

<input type="checkbox"/> Loss or Impairment of a Foot, Leg, Finger, Thumb, or Hand - Condition: _____	<input type="checkbox"/> Cognitive impairment: _____
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Neuropsychiatric Disorder: _____
<input type="checkbox"/> Cerebral Vascular Disease	<input type="checkbox"/> Psychiatric Disorder: _____
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Vision Deficiency: <input type="checkbox"/> Acuity <input type="checkbox"/> Visual Fields
<input type="checkbox"/> Loss of Consciousness - Cause: _____	<input type="checkbox"/> Other Medical Condition that would interfere with the patient's ability to drive. Explain: _____
<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Sleep Apnea: _____
<input type="checkbox"/> Neuromuscular Disorder: _____	<input type="checkbox"/> Alcohol Use: _____
<input type="checkbox"/> Single Seizure: Date of Seizure: _____	<input type="checkbox"/> Drug or Controlled Substance Use: _____
<input type="checkbox"/> Seizure Disorder: <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Last Seizure: _____	

NOTE: A seizure disorder- More than one seizure or a single seizure of electrically diagnosed epilepsy.

Patient meets following seizure waiver, therefore no action should be taken on the driving privilege:

<input type="checkbox"/> 2 year history of strictly a nocturnal pattern of seizures or a pattern of seizures occurring only immediately upon awakening
<input type="checkbox"/> 2 year history of a specific prolonged aura accompanied by sufficient warning
<input type="checkbox"/> Patient has been seizure free for the previous 6 months and above referenced seizure occurred as a result of a prescribed change in or removal from medication. Patient's previous medication has been reinstated.
<input type="checkbox"/> Patient has been seizure free for previous 6 months and above referenced seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance.

Should this individual cease driving immediately? YES NO

If not, does the condition(s) warrant further investigation of driving competency by the Department? YES NO

SECTION C

ALL INFORMATION IS CONFIDENTIAL AS PROVIDED IN THE PA VEHICLE CODE, SECTION 1518(d)

HEALTH CARE PROVIDER'S NAME		SPECIALTY		HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS		CITY		STATE	ZIP CODE
TELEPHONE NUMBER			FAX NUMBER		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to \$2,500 and/or imprisonment up to 1 year.

_____ Health Care Provider's Signature _____ Date _____