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WASHINGTON STATE DEPARTMENT OF LICENSING

Physical Examination Report

Failure to return this completed form by _____ to Department of Licensing (DOL) may result in the suspension of the driver's driving privilege.

Mail or fax completed report to:
Restricted Licensing
Department of Licensing
PO Box 9030
Olympia, WA 98507
Fax: **(360) 570-7893**
Email: **MedicalCerts@dol.wa.gov**

Driver/Patient information

Name *(Last, First, Middle)*

Date of birth	(Area code) Daytime telephone number	Driver license number

Consent to release information

*I authorize the licensed MD, DO, Naturopath, RN, ARNP, PA, PAC, DPM, Psychiatrist, or Psychologist below to provide information regarding my medical condition from my examination **done in the past 3 months**. I understand the Department of Licensing will use this information to arrive at a decision regarding my ability to safely operate a motor vehicle.*

X When you have completed this form, please print it out and sign here.
Driver signature Date

X When you have completed this form, please print it out and sign here.
Signature of parent (if minor) Date

Medical provider – MD, DO, Naturopath, RN, ARNP, PA, PAC, DPM, Psychiatrist, or Psychologist ONLY

DOL has reason to believe the driver named above may have a condition that could affect the safe operation of a motor vehicle.

Your knowledge of this person's condition is of great value in assisting us determine a proper licensing decision. **DOL has sole responsibility for any decision** regarding driving qualifications and licensure. **Answer ALL questions** and return to DOL.

How long has this person been your patient?	Date of examination **(within last 3 months)**

Answer the following

1. To your knowledge, has this person lost consciousness in the past 6 months? . . . . . ☐ Yes ☐ No
2. Based on this examination, did you find a medical condition that may affect this person's ability to drive? . . . . ☐ Yes ☐ No

If "Yes" to either question 1 or 2, answer the following:

a. Medical condition: *(select all that apply)*
- ☐ Loss of consciousness or control/seizure – Month and year of most recent occurrence: _____
- ☐ Sleep apnea, narcolepsy, sleep disorder – Month and year of most recent occurrence: _____
- ☐ Dementia or cognitive impairment – Have you noticed a decline over the past 12 months? . . . . . ☐ Yes ☐ No
- ☐ Loss of muscular control/mobility – Have you noticed a decline over the past 12 months? . . . . . ☐ Yes ☐ No
- ☐ Other _____

b. This person's condition:
☐ Is controlled/stable ☐ Is controlled by medication that may affect their ability to drive ☐ May interfere with driving

c. In your professional opinion, is this person able to safely operate a motor vehicle? . . . . . ☐ Yes ☐ No ☐ Unsure
If "No", have you advised this person not to drive? . . . . . ☐ Yes ☐ No

d. Should DOL monitor this driver's condition with periodic Physical Examination Reports? . . . . . ☐ Yes ☐ No
If "Yes", how often? . . . . . ☐ 6 months ☐ 1 year ☐ 2 years

Comments/Other conditions that may affect this person's driving

Medical provider name	Professional license number

Address *(Street address, City, State, ZIP code)*

(Area code) Telephone number	(Area code) Fax number	Email

I certify under penalty of perjury under the laws of the state of Washington that the information I have provided is true and correct.

Date Place (city or county) signed

X When you have completed this form, please print it out and sign here.
Medical provider signature (MD, DO, Naturopath, RN, ARNP, PA, PAC, DPM, Psychiatrist, Psychologist **ONLY**)

RCW 46.20.041; 46.20.305