Haga clic aquí para INICIAR o BORRAR, luego presione el botón TAB

WASHINGTON STATE DEPARTMENT OF LICENSING

Informe del Examen Físico

Si no devuelve este formulario llenado antes del _____ al Department of Licensing (DOL), puede ocasionar la suspensión del derecho a conducir del conductor.

Envíe el informe completo por correo o fax a:
Restricted Licensing
Department of Licensing
PO Box 9030
Olympia, WA 98507
Fax: **(360) 570-7893**
Correo electrónico:
MedicalCerts@dol.wa.gov

Información del conductor o paciente

Nombre *(apellido, primer nombre, segundo nombre)*

Fecha de nacimiento	(Código de área) número de teléfono durante el día	Número de licencia para conducir

Consentimiento para revelar información
Autorizo al médico (doctor of medicine, MD), osteópata (doctor of osteopathic medicine, DO), naturópata, enfermero registrado (registered nurse, RN), enfermero registrado de práctica avanzada (advanced registered nurse practitioner, ARNP), auxiliar médico (physician assistant, PA), asociado médico certificado (physician assistant-certified, PAC), psiquiatra o psicólogo que se indica a continuación que proporcione información sobre mi estado de salud con base en el examen médico . Entiendo que el Department of Licensing usará esta información para llegar a una decisión sobre mi capacidad para operar con seguridad un vehículo motorizado.

X Cuando haya llenado este formulario, imprímalo y firme aquí.
Firma del conductor Fecha

X Cuando haya llenado este formulario, imprímalo y firme aquí.
Firma del padre (en caso de menores) Fecha

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