PHYSICAL EXAMINATION REPORT

For S or P Endorsement
Wisconsin Department of Transportation (WisDOT)
MV3030B 01/2023 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code
Incomplete forms will be returned for completion.

Medical Review, PO Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327 FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

Applicant Name	Driver License Number (1 2 3 4 – 5 6 7 8 – 9 10 11 12 – 13 14)	Birth Date (M M – D D – Y Y Y Y)
Street Address / City / State / ZIP Code		(Area Code) Telephone Number

Note: Pursuant to Trans 112, Wis. Admin. Rules (copy available upon request); this report is to be completed prior to consideration for licensing. The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver's licensing. Any charges or fees for the medical or vision examinations and the preparation or completion of this form are responsibility of the applicant (driver).

VISION SECTION – REQUIRED

Numerical readings must be provided.			**YES**	**NO**	
ACUITY	UNCORRECTED	CORRECTED	☐	☐	Is the temporal field of vision at least 70 degrees from center in **each** eye?
Right Eye	20/	20/	☐	☐	Can the applicant recognize and distinguish the colors red, amber, and green?
Left Eye	20/	20/	☐	☐	Are corrective lenses required when driving?

X	Medical License No. (if different from below) (1 2 3 4 5 – 6 7 8)	Date (m/d/yyyy, if different from below)
(Examining Authority Signature, only if different from below)		

SECTION A YES	**NO**	**APPLICANT completes section A when holding/applying for P and S endorsement.** / **HEALTH CARE PROFESSIONAL completes section B for applicant holding/applying for S endorsement.**	**SECTION B YES**	**NO**
☐	☐	Alcohol or other drug abuse or dependency within the past 12 months	☐	☐
☐	☐	Alcohol or other drug abuse or dependency within the past 12–24 months not controlled by treatment	☐	☐
☐	☐	Neuro/Muscular disease, e.g., ALS, MS, Head Trauma	☐	☐
☐	☐	Diabetes or elevated blood sugar controlled by: ☐ Diet ☐ Pills ☐ Insulin	☐	☐
☐	☐	Heart disease or heart attack, stroke, other cardiovascular condition	☐	☐
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date: _____	☐	☐
☐	☐	Pulmonary disease or condition, positive TB communicable form, emphysema, COPD	☐	☐
☐	☐	Required oxygen use	☐	☐
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	☐	☐
☐	☐	Loss of body control, or altered consciousness Date: _____	☐	☐
☐	☐	Seizures, epilepsy Date of last episode: _____	☐	☐
☐	☐	Kidney disease, dialysis	☐	☐
☐	☐	Blood pressure over 180/105 (**If yes**, provide 3 BP readings taken over a 2-week period, separated by at least 1 day)	☐	☐
☐	☐	Mental/Emotional Conditions	☐	☐
☐	☐	Missing or impaired hand, arm, foot, leg	☐	☐
N/A	N/A	Inability to hear instructions given in normal conversational tone ☐ Corrected by Hearing aid	☐	☐
N/A	N/A	Any medication that would interfere with the safe operation of a school bus	☐	☐
APPLICANT:		For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.		

I certify that the answers and statements made on this report are true and correct. I authorize the examining health care professional to release full details of an examination upon request to my employer, the School Board and the Wisconsin Department of Transportation.

X
(Applicant Signature) (Date – m/d/yyyy)

HEALTH CARE PROFESSIONAL:	For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently. Please use the back of this form for additional comments, if needed.

Would you recommend any additional medical evaluation?

Additional Comments:

This report must be based on an examination conducted within the past 90 days. I certify that I have examined this applicant and that I am licensed to practice _____ (MD, DO, PA-C, APNP, DC).

Print Name	Patient Examination Date	(Area Code) Office Telephone No.
X (Authorized Signature)	Medical License No. (1 2 3 4 5 – 6 7 8)	National Registry No. – Chiropractor Only (1 2 3 4 – 5 6 7 8 – 9 10)