Medical Examination Form Instructions

1. This medical form must be completed in its entirety, including **your signature and date in section I.**

2. The **Date of Examination** must not be over **90 days old**.

3. This form must be completed by a **PHYSICIAN.**

4. This form must include (**on page 1**):

    - **PHYSICIAN'S printed name and signature**
    - **phone number**
    - **office address**

5. Nurse Practitioner or Physician Assistant WILL **NOT** be accepted.

6. This form must include all **medications, dosage** and **frequency**.

7. If this form is faxed to our office **YOU** must call **502-564-1257** to verify that it has been received.

KENTUCKY TRANSPORTATION CABINET
Department of Vehicle Regulation
MEDICAL REVIEW OFFICE

MEDICAL REVIEW BOARD EXAMINATION

MRB Case # ______________

Mail to: Medical Review Office, 200 Mero Street, Frankfort, KY 40622, or email to KYTC.MedicalReviewBoard@ky.gov
Phone: (502) 564-1257 FAX: (844) 503-4111

Instructions: Section 1 must be completed and signed by the driver/applicant. Section 2 must be completed by a licensed physician (MD/DO). The driver/applicant is responsible for all costs associated with this examination.

SECTION 1: DRIVER/APPLICANT INFORMATION (*Please print or type.*)

Pursuant to 601 KAR 13:090, provide the following information and sign the Agreement/Release of Information as a condition of licensure.

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	
ADDRESS (*street*)	**CITY**	**STATE**	**ZIP**
HOME PHONE	**ALTERNATE PHONE**	**EMAIL ADDRESS**	
DRIVER'S LICENSE NO.	**GENDER** ☐ Male ☐ Female	**DATE OF BIRTH** (*mm/dd/yyyy*)	

Do you have a Commercial Driver's License? ☐ Yes ☐ No

Agreement/Release of Information

I hereby authorize and request that my physician release information and records regarding my medical condition and treatment to the Kentucky Transportation Cabinet and its employees or agents, and to report any change in my condition or treatment that may impair my ability to safely operate a motor vehicle. I consent to the Cabinet and its employees or agents using this information to determine my ability to safely operate a motor vehicle. I understand that failure to abide by the conditions set forth in this agreement shall result in suspension or denial of my driving privileges. This agreement shall remain valid for one year.

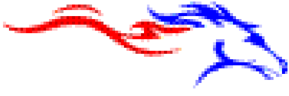
Signature of Driver/Applicant ______________________ **Date Signed** (*mm/dd/yyyy*) ______________________

SECTION 2: PHYSICIAN (MD/DO) INFORMATION (*Please print or type.*)

Pursuant to 601 KAR 13:090, Section 2 must be completed in its entirety by a licensed physician (MD/DO). Forms signed by providers other than physicians cannot be accepted.

PROVIDER'S NAME	**TITLE** ☐ **M.D.** ☐ **D.O.**	**MEDICAL SPECIALTY**	
PROFESSIONAL LICENSE NO.	**MEDICAL LICENSE ISSUANCE** (*state*)	**OFFICE PHONE NUMBER**	
BUSINESS ADDRESS (*street*)	**CITY**	**STATE**	**ZIP**

PHYSICIAN'S SIGNATURE (*stamped signature unacceptable*) ______________________ **DATE SIGNED** (*mm/dd/yyyy*) ______________________



MEDICAL REVIEW BOARD EXAMINATION

1. Date of examination (mm/dd/yyyy): ______________________ (must be within the past 90 days)
2. Vital signs: Pulse: __________ Blood Pressure __________ Respiratory Rate __________
3. How long has this individual been your patient? ______________________
4. Are you a regular or primary care provider for this individual? ☐ Yes ☐ No
   If no, list his or her regular or primary care provider:

   ____
   Name City, State Medical Specialty
5. Indicate whether this individual has been diagnosed with any conditions in the following categories. (Check "Yes" or "No" for each category. If you check "Yes," list all diagnoses or symptoms relevant to that category.)

   Cardiovascular ☐ Yes ☐ No ______________________

   Cerebrovascular ☐ Yes ☐ No ______________________

   Endocrine ☐ Yes ☐ No ______________________

   Musculoskeletal ☐ Yes ☐ No ______________________

   Neurological ☐ Yes ☐ No ______________________

   Neuromuscular ☐ Yes ☐ No ______________________

   Mental/Emotional ☐ Yes ☐ No ______________________

   Respiratory ☐ Yes ☐ No ______________________

   Seizure disorder ☐ Yes ☐ No ______________________

   Substance abuse ☐ Yes ☐ No ______________________

   Vision/Sensory ☐ Yes ☐ No ______________________

   Other ☐ Yes ☐ No ______________________
6. In your professional opinion, do any of the conditions listed above **currently impair** this individual's ability to safely operate a motor vehicle? ☐ Yes ☐ No ☐ Not Applicable (no diagnosis listed)
   If yes, list the condition and how it impairs driving:

   ____

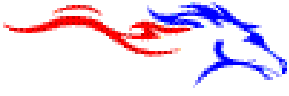
   ____
7. In your professional opinion, is this individual **physically fit** to safely operate a motor vehicle? ☐ Yes ☐ No
   If no, list the condition and how it impairs driving:

   ____

   ____
8. In your professional opinion, is this individual **mentally fit** to safely operate a motor vehicle? ☐ Yes ☐ No
   If no, list the condition and how it impairs driving:

   ____

   ____



KENTUCKY TRANSPORTATION CABINET
Department of Vehicle Regulation
MEDICAL REVIEW OFFICE

MEDICAL REVIEW BOARD EXAMINATION

9. Does this individual have any conditions that require further evaluation or testing? ☐ Yes ☐ No
   If yes, list the condition(s) and how it impairs driving:

   ____

   ____

10. Does this individual have a history of Epilepsy, seizures, blackouts, or loss of consciousness? ☐ Yes ☐ No
    If yes, provide ALL of the following:
    Diagnosis/Condition: ____________________
    Date of last seizure/episode (*mm/dd/yyyy*) ____________________
    Medications and dosage (for above conditions only): ____________________
    ☐ Check here if this individual does not take any medications for this condition.

11. Do you prescribe any controlled substances to this individual? ☐ Yes ☐ No
    If yes, attach the most recent KASPER report in this individual's medical record.

12. List all medications prescribed to this individual by **you or other providers in your practice**, including controlled substances. **For each medication listed, the condition for which the medication is prescribed must be indicated.** If no medications are prescribed to this individual, please indicate so by checking the box below. If more space is needed, a medication list may be attached.

Medication	Dosage	Diagnosis/Condition

☐ Check here if no medications are prescribed.

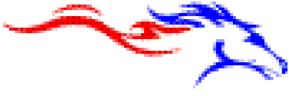
13. Is this individual prescribed controlled substances by any **other** physicians? ☐ Yes ☐ No
    If yes, list the controlled substances, dosage, and prescribing physician below:

Controlled Substance	Dosage	Prescribing Physician

14. In your professional opinion, do any of the medications listed above **currently impair** this individual's ability to safely operate a motor vehicle? ☐ Yes ☐ No ☐ Not applicable (no medications prescribed)
    If yes, list the medication and how it impairs driving:

    ____

    ____



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15. **Note**: **Visual acuity may be measured by the attending physician using a standard vision chart (Snellen). An ophthalmologist or optometrist assessment is not necessary.**

VISUAL ACUITY		
Eye(s) Examined:	Without corrective lenses:	With corrective lenses:
(OD) Right Eye:	20/	20/
(OS) Left Eye:	20/	20/
(OU) Both Eyes:	20/	20/

16. To your knowledge, has this individual been diagnosed with any ophthalmic conditions that should be further evaluated by a vision specialist? ☐ Yes ☐ No

17. Do you recommend driving restrictions for this individual (daylight only, no interstate, limitation of distance, adaptive equipment, etc.)? ☐ Yes ☐ No
If yes, specify reason for restriction(s):

___

___

18. Do you recommend that this individual complete a road test given by Kentucky State Police? ☐ Yes ☐ No
If yes, for what medical condition(s)?

___

___

19. Do you recommend that this individual complete a formal driving evaluation given by a Certified Driving Rehabilitation Specialist? ☐ Yes ☐ No

20. Please provide additional information, comments, or recommendations relating to this individual's ability to safely operate a motor vehicle:

___

___

___

Please maintain a copy of this examination for your records.