

# Physical Examination Report

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

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

<b>Driver/Patient information</b>		
Name (Last, First, Middle) _____		
Date of birth _____	10-digit daytime phone number _____	Driver license number _____
Consent to release information <i>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 <b>done in the past 3 months</b>. I understand the Department of Licensing will use this information to arrive at a decision regarding my ability to safely operate a motor vehicle.</i>		
<b>X</b> _____ Driver signature	_____ Date	<b>X</b> _____ 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) _____
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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

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) _____		
10-digit phone number _____	10-digit fax number _____	Email _____

*I declare under penalty of perjury under the law of Washington that the information I have provided is true and correct.*

**X**

Date _____	Place (city or county) signed _____	Medical provider signature (MD, DO, Naturopath, RN, ARNP, PA, PAC, DPM, Psychiatrist, Psychologist <b>ONLY</b> ) _____
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