

INITIAL REPORTING FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION



Bureau of Driver Licensing
 P.O. Box 68682
 Harrisburg, PA 17106-8682
 (717) 787-9662

DEAR PROVIDER: For a copy of the Physical and Mental Criteria, including Vision Standards relating to the licensing of drivers, visit <http://www.pacode.com/secure/data/067/chapter83/chap83toc.html>.

SECTION A PATIENT INFORMATION													
DRIVER'S LICENSE NO.			LAST NAME(S)				JR. ETC	FIRST NAME					
HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER			SOCIAL SECURITY NUMBER			
FEET	INCHES			MONTH	DAY	YEAR	()		-		-	
STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.							CITY			STATE	ZIP CODE		

DATE OF EXAMINATION: _____

How long have you been treating the patient? _____

SECTION B	
DIAGNOSIS OF DISORDER OR DISABILITY: <i>Please Check (✓) Appropriate Items</i>	
<input type="checkbox"/> Loss or Impairment of a Foot, Leg, Finger, Thumb, or Hand - Condition: _____ <input type="checkbox"/> Unstable Diabetes <input type="checkbox"/> Cerebral Vascular Disease <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Loss of Consciousness - Cause: _____ <input type="checkbox"/> Neurological Disorder <input type="checkbox"/> Neuromuscular Disorder: _____ <input type="checkbox"/> Single Seizure: Date of Seizure: _____ <input type="checkbox"/> Seizure Disorder: <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Last Seizure: _____	<input type="checkbox"/> Cognitive impairment: _____ <input type="checkbox"/> Neuropsychiatric Disorder: _____ <input type="checkbox"/> Psychiatric Disorder: _____ <input type="checkbox"/> Alcohol Abuse: BAC _____ <input type="checkbox"/> Drug or Controlled Substance Abuse: _____ <input type="checkbox"/> Vision Deficiency: <input type="checkbox"/> Acuity <input type="checkbox"/> Visual Fields <input type="checkbox"/> Other Medical Condition that would interfere with the patient's ability to drive. Explain: _____
NOTE: A seizure disorder- More than one seizure or a single seizure of electrically diagnosed epilepsy.	
Patient meets following seizure waiver, therefore no action should be taken on the driving privilege:	
<input type="checkbox"/> 2 year history of strictly a nocturnal pattern of seizures or a pattern of seizures occurring only immediately upon awakening <input type="checkbox"/> 2 year history of a specific prolonged aura accompanied by sufficient warning <input type="checkbox"/> Patient has been seizure free for the previous 6 months and above referenced seizure occurred as a result of a prescribed change in or removal from medication. Patient's previous medication has been reinstated. <input type="checkbox"/> Patient has been seizure free for previous 6 months and above referenced seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance.	
Should this individual lose his/her driving privilege immediately? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If not, does the condition(s) warrant further investigation of driving competency by the Department? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION C			
ALL INFORMATION IS CONFIDENTIAL AS PROVIDED IN THE PA VEHICLE CODE, SECTION 1518(d)			
HEALTH CARE PROVIDER'S NAME		SPECIALTY	STATE MEDICAL LICENSE #
STREET ADDRESS		CITY	STATE ZIP CODE
TELEPHONE ()		FAX ()	
I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to \$2,500 and/or imprisonment up to 1 year.			
_____ Health Care Provider's Signature			_____ Date