



MISSOURI DEPARTMENT OF REVENUE
 DRIVER LICENSE BUREAU, P.O. BOX 200
 301 WEST HIGH STREET, ROOM 470
 JEFFERSON CITY, MO 65105-0200

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FORM
1528
 (REV. 10-2012)

PHYSICIAN'S STATEMENT

DRIVER OR PATIENT SECTION	PATIENT NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	
	PATIENT'S MAILING ADDRESS	CITY	STATE	ZIP CODE

I hereby authorize and accept that:

- My physician will conduct a medical examination to determine my fitness to operate a motor vehicle safely and responsibly.
- My physician will respond to any additional questions from the Driver License Bureau (DLB) and, if necessary, he or she may submit copies of my medical records to the DLB.
- The DLB will make a final decision concerning my eligibility for driver licensure based on all available information.

Signature of Driver or Patient _____ Date (MM/DD/YYYY) _____

DRIVER AND PATIENT (respond to all questions below before seeing your physician)

- How many driving trips do you make in a typical week? _____
- Do any of your regular trips involve driving at night? Yes No
- What is the one-way distance of your furthest regular trip? _____ miles
- Do any of your regular trips involve speeds \geq 55 MPH? Yes No
- Were you pulled over by a police officer in the past year? Yes No
- Were you involved in a crash as a driver in the past year? Yes No

7. In addition to driving, what other modes of transportation do you use regularly? (check all that apply)

- Ride with Family Member or Friend
- Walk or Ride a Bicycle
- Public Bus, Van or Train
- Private Bus, Van or Taxi
- Other _____

PHYSICIAN SECTION

Pursuant to Section 302.291 RSMo, completing this report does not violate physician or patient privilege, and when in good faith, the physician shall be immune from any civil liability that might otherwise result from making this report. **INSTRUCTIONS:** Use your best clinical judgement as you REVIEW AND

COMPLETE ALL SECTIONS. Attach additional sheets as necessary. Base severity ratings within each category on your overall assessment of impairment relative to the driving task.

EXAMINATION DATE (MM/DD/YYYY): _____

- _____ Supplemental page(s) attached.
- Are you a regular or primary care provider for this patient?** Yes No
- If yes, how many times have you seen this patient in the past year? _____
- If no, are you evaluating this patient for the first time today? Yes No
- If no, have you reviewed the patients medical records? Yes No

To your knowledge, is this patient:

- Aware of his or her medical diagnosis & status?
 Yes Somewhat No
- Aware of functional impairments that may impact driving?
 Yes Somewhat No
- Compliant with medications & basic requirements of self-care?
 Yes Somewhat No

VISION & HEARING

- Macular Degeneration Glaucoma Cataracts
- Field Deficit on Confrontation Retinopathy Other Vision _____
- Significant Hearing Loss (**for commercial drivers only**)
- Should** patient be required to wear glasses or lenses while driving? Yes No
- Should** patient be restricted to daylight driving? Yes No
- Does** patient have visual field deficit which makes driving unsafe? Yes No

Does this patient have:

- Cardiovascular Disease Yes No
- Cardiac Arrhythmia Yes No
- Heart Failure Yes No
- History of MI Yes No
- History of Syncope Yes No

AHA Functional Capacity

(circle level if applicable)

I II III IV

Distance Acuity	LEFT	RIGHT	BOTH
With Correction	20/	20/	20/
W/O Correction	20/	20/	20/
Field Width °			
Date (MM/DD/YYYY)	Phone		
_____/_____/_____	(_____) _____ - _____		
Licensed Physician Name (printed)			
Signature (required)			
License #			

CURRENT MEDICATIONS (check all that apply)

- Sedative CNS Stimulant Antidepressant Insulin
- Narcotic Tranquilizer Antihistamine Digitalis
- Anticonvulsant Anticoagulant Anti-Infective Sleep Aid
- Other _____

To your knowledge, is this patient subject to any consistent side effects or interactions that may impair driving ability?
 Yes Possibly Not Likely No

COGNITIVE, CEREBROVASCULAR OR NEUROLOGICAL

Condition is: Permanent Temporary

Mental Status _____

(list test and score)

- Confusion or Disorientation Memory Loss or Forgetfulness
- Inattention or Distractibility Impaired Judgement
- Visual-Spatial Deficit Slowed Processing Speed

- Cognitive Impairment Cerebrovascular Disease Neurological Condition
- Alzheimer's Disease Cerebral Infraction or Stroke Brain Injury (open or closed)
- Vascular Dementia Hemorrhage or Aneurysm Tumor or Malformation
- Frontotemporal or Pick's Transient Ischemic Attack Parkinson's Disease
- Dementia (other or unknown) Carotid Occlusion or Hypoxia Multiple Sclerosis

Combined Impairment for Driving

Check (X) Highest Level for Section →

UNIMPAIRED <i>Likely Fit to Drive</i>	VERY MILD <i>Likely Fit to Drive</i>	MILD <i>Questionable Fitness</i>	MODERATE <i>Likely Unfit to Drive</i>	SEVERE <i>Likely Unfit to Drive</i>
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CONSCIOUSNESS, METABOLIC OR RESPIRATORY

Condition is: Permanent Temporary

*DATE of last event with impaired consciousness (MM/DD/YYYY): _____

- Disorder of Consciousness or Alertness*
 - Blackout or Syncope* Sleep Apnea or Narcolepsy
 - Medication Effect Chronic Sleep Deprivation
 - Epilepsy or Seizure Disorder Dizziness or Postural Hypotension

- Metabolic Condition
 - Diabetes (Type 1 or 2)
 - Thyroid Condition (Hypo or Hyper)
 - Morbid Obesity or Fluid Retention
- Respiratory Condition
 - Asthma or Shortness of Breath
 - COPD
 - Oxygen Dependent

Combined Impairment for Driving

Check (X) Highest Level for Section →

UNIMPAIRED <i>Likely Fit to Drive</i>	VERY MILD <i>Likely Fit to Drive</i>	MILD <i>Questionable Fitness</i>	MODERATE <i>Likely Unfit to Drive</i>	SEVERE <i>Likely Unfit to Drive</i>
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MUSCULOSKELETAL, MOVEMENT OR NEUROMUSCULAR

Condition is: Permanent Temporary

CHECK ALL THAT APPLY

- Arthritis (Osteo or Rheumatoid) Frailty or Generated Weakness
- Uses Cane or Walker Paralysis - Arm
- Wheelchair Dependent Paralysis - Leg
- Difficulty Transferring Prosthesis or Brace - Arm
- Problems with Balance Prosthesis or Brace - Leg

- Motor Neuron Disease Muscular Dystrophy
- Multiple Sclerosis Parkinson's Disease
- Restricted or Weakness - Arm Loss of Limb
- Restricted or Weakness - Leg History of Falls
- Restricted Neck Range of Motion Other _____
- Orthopedic or Movement

Combined Impairment for Driving

Check (X) Highest Level for Section →

UNIMPAIRED <i>Likely Fit to Drive</i>	VERY MILD <i>Likely Fit to Drive</i>	MILD <i>Questionable Fitness</i>	MODERATE <i>Likely Unfit to Drive</i>	SEVERE <i>Likely Unfit to Drive</i>
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PSYCHIATRIC, EMOTIONAL OR ADDICTION

Condition is: Permanent Temporary

- Depression Bipolar Mood Disorder Psychosis or Schizophrenia Alcohol Abuse or Addiction Drug Abuse or Addiction
- Suicidal or Homicidal Anxiety or Post-Traumatic Stress Chronic Pain (causing distress) Other _____

Combined Impairment for Driving

Check (X) Highest Level for Section →

UNIMPAIRED <i>Likely Fit to Drive</i>	VERY MILD <i>Likely Fit to Drive</i>	MILD <i>Questionable Fitness</i>	MODERATE <i>Likely Unfit to Drive</i>	SEVERE <i>Likely Unfit to Drive</i>
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Based on my observations of this patient and information relayed to me by this individual, I, reasonably and in good faith, believe that _____ PATIENT NAME is:

MUST CHOOSE ONE →

- LIKELY CAPABLE** of operating a motor vehicle safely and responsibly. There are no medical contraindications at this time. No further evaluation appears to be needed.
- UNCLEAR IF CAPABLE** of operating a motor vehicle safely and responsibly due to current medical-functional status. I recommend additional evaluations to include:
 - Driving Skills Examination Evaluation by Vision Specialist
 - Written Examination Evaluation by Specialist _____
- NOT CAPABLE** of operating a motor vehicle safely and responsibly due to significant medical-functional compromise or deficit.

Recommended license restriction(s):

- Daylight Driving Only
- No Highway Driving
- Outside Rearview Mirror
- Special Hand Device
- 25 Mile Radius Only
- Restricted 25 MPH
- Restricted 45 MPH
- Specialty Cushion
- Special Foot Device
- Other _____

SPECIALTY	LICENSE NUMBER	PHONE (____) ____ - _____
OFFICE MAILING ADDRESS (INCLUDING ZIP CODE)		

PHYSICIAN NAME (PRINTED)	SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY) ___/___/_____
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