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MISSOURI DEPARTMENT OF REVENUE
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JEFFERSON CITY, MO 65105-0200

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PHYSICIAN'S STATEMENT

FORM **1528** (REV. 04-2019)

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**

Driver responses to the information below is requested for full evaluation purposes, but is not mandatory for completion and submission of the form by eligible medical provider.

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)

1. How many driving trips do you make in a typical week? _____
2. Do any of your regular trips involve driving at night? ☐ Yes ☐ No
3. What is the one-way distance of your furthest regular trip? _____ miles
4. Do any of your regular trips involve speeds ≥ 55 MPH? ☐ Yes ☐ No
5. Were you pulled over by a police officer in the past year? ☐ Yes ☐ No
6. 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

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 °			

VISION & HEARING

☐ Macular Degeneration ☐ Glaucoma ☐ Cataracts
☐ Field Deficit on Confronation ☐ 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

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**
☐ Alzheimer's Disease
☐ Vascular Dementia
☐ Frontotemporal or Pick's
☐ Dementia (other or unknown)

☐ **Cerebrovascular Disease**
☐ Cerebral Infraction or Stroke
☐ Hemorrhage or Aneurysm
☐ Transient Ischemic Attack
☐ Carotid Occulsion or Hypozxia

☐ **Neurological Condition**
☐ Brain Injury (open or closed)
☐ Tumor or Malformation
☐ Parkinson's Disease
☐ Multiple Sclerosis

Combined Impairment for Driving
Check (X) Highest Level for Section →

UNIMPAIRED	VERY MILD	MILD	MODERATE	SEVERE
Likely Fit to Drive	*Likely Fit to Drive*	*Questionable Fitness*	*Likely Unfit to Drive*	*Likely Unfit to Drive*

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	VERY MILD	MILD	MODERATE	SEVERE
Likely Fit to Drive	*Likely Fit to Drive*	*Questionable Fitness*	*Likely Unfit to Drive*	*Likely Unfit to Drive*

MUSCULOSKELETAL, MOVEMENT OR NEUROMUSCULAR

Condition is: ☐ **Permanent** ☐ **Temporary**

CHECK ALL THAT APPLY

☐ Arthritis (Osteo or Rheumatoid)
☐ Uses Cane or Walker
☐ Wheelchair Dependent
☐ Difficulty Transferring
☐ Problems with Balance
☐ Frailty or Generated Weakness
☐ Paralysis - Arm
☐ Paralysis - Leg
☐ Prosthesis or Brace - Arm
☐ Prosthesis or Brace - Leg
☐ Motor Neuron Disease
☐ Multiple Sclerosis
☐ Restricted or Weakness - Arm
☐ Restricted or Weakness - Leg
☐ Restricted Neck Range of Motion
☐ Orthopedic or Movement
☐ Muscular Dystrophy
☐ Parkinson's Disease
☐ Loss of Limb
☐ History of Falls
☐ Other _____

Combined Impairment for Driving
Check (X) Highest Level for Section →

UNIMPAIRED	VERY MILD	MILD	MODERATE	SEVERE
Likely Fit to Drive	*Likely Fit to Drive*	*Questionable Fitness*	*Likely Unfit to Drive*	*Likely Unfit to Drive*

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	VERY MILD	MILD	MODERATE	SEVERE
Likely Fit to Drive	*Likely Fit to Drive*	*Questionable Fitness*	*Likely Unfit to Drive*	*Likely Unfit to Drive*

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)
		__ __ / __ __ / __ __ __ __