

## Physical Examination Report

You can use this form to provide us with information regarding a driver's ability to safely operate a motor vehicle. Mail completed form to: **Medical Unit, Department of Licensing, PO Box 9030, Olympia, WA 98507**, or fax **(360) 570-7893**.

**Driver** – Complete this section and sign the consent to release information. Have your medical examiner complete this form. The medical examiner will send the completed form to us.

Name (Last, First, Middle)		Date of birth	Today's date
(Area code) Daytime telephone number	(Area code) Home telephone number	Driver license number	
Consent to release information  <i>I authorize _____, a licensed physician M.D., D.O., Naturopath, Psychiatrist, Psychologist, R.N., A.R.N.P., P.A., or P.A.C. to provide information regarding my medical condition from my examination <b>conducted within 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		<b>X</b> _____ Signature of parent (if minor)	

**Medical examiner** – Please complete the following and mail to: **Medical Unit, Department of Licensing, PO Box 9030, Olympia, WA 98507** or fax **(360) 570-7893**.

1. Does this individual have a condition which may cause a loss of consciousness or control? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate month and year of most recent occurrence: _____ Comments _____ _____ _____			
2. Does this individual have a condition which may interfere with driving? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No Comments _____ _____ _____			
3. Should this individual be required to submit periodical medical examination reports as a condition of licensing? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often? <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years Comments _____ _____ _____			
Medical examiner name		Professional license number	Exam date
Street address			
City	State	ZIP code	(Area code) Telephone number

*I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.*

\_\_\_\_\_ **X** \_\_\_\_\_  
 Date and place Signature of medical examiner

If this Department has reason to believe that a person is suffering from a physical or mental disability or disease that may affect that person's ability to drive a motor vehicle, we must evaluate whether the person is able to safely drive. As part of the evaluation, we may require the person to obtain a statement signed by a licensed physician or other proper authority designated by us, certifying the person's condition. RCW 46.20.041; 46.20.305.