Government of **Western Australia**
Department of **Transport**
Driver and Vehicle Services

M108A

Medical Assessment Certificate
Senior driver's licence renewal declaration

Prior to the renewal of your driver's licence, you must take this form to your health professional who will conduct an assessment of your fitness to drive a motor vehicle. Please read the detailed medical assessment instructions (M106A) for the applicant and health professional.

This form may be submitted to the Department of Transport (DoT) via email to driver.assessment@transport.wa.gov.au, or post to the Occupational Health Physician, C/O Department of Transport, GPO Box R1290, PERTH WA 6844. Please mark as Confidential.

Applicant details - to be completed by applicant or Department of Transport

FAMILY NAME	
GIVEN NAMES	DATE OF BIRTH
RESIDENTIAL ADDRESS	

Licence details current and proposed.
Please circle the class/es of vehicle you are currently authorised to drive or are proposing to drive.

STANDARD	PRIVATE			COMMERCIAL						
TYPE OF VEHICLE	MOTOR CAR	MOTORCYCLE	LIGHT RIGID	MEDIUM RIGID	HEAVY RIGID	HEAVY COMBINATION	MULTI COMBINATION	DRIVER INSTRUCTORS	TAXI	CARRY PASSENGERS FOR REWARD
CLASS	☐ C	☐ R	☐ LR	☐ MR	☐ HR	☐ HC	☐ MC	☐ DI	☐ T EXTENSION	☐ F EXTENSION

REASON FOR REFERRAL

DRIVER'S LICENCE / PERMIT NO:	EXPIRY DATE:
APPLICATION TYPE:	
APPLICANT HAS DECLARED THAT: **HE/SHE SUFFERS FROM** **HE/SHE TAKES AS MEDICATION**	

DOT#22 v7

DRIVING HISTORY WITHIN THE LAST 3 YEARS

1. Have you been convicted of a traffic offence? (Including an Infringement Notice) ☐ Yes ☐ No

2. Have you been involved in a traffic crash? ☐ Yes ☐ No

If YES, which State/Town/Suburb? _____

MEDICAL QUESTIONS

Do you suffer from any medical condition that may affect your ability to drive a motor vehicle? Yes ☐ No ☐
If **Yes**, please give details and specify treatment where applicable

Medical condition: _____

Treatment/Medications: _____

I consent to any reporting health professional named on this form releasing information to the Department of Transport (DoT) and DoT contacting any reporting health professional named on this form to obtain any further information relevant to my fitness to drive.

I certify that I have completed all relevant sections above and all information is true and correct.

Signature of applicant _____ Phone Number _____ Date _____

PLEASE NOTE: It is unlawful to provide false or misleading information. A penalty may be imposed.

Enquiries 13 11 56

Assessment of Fitness to Drive - to be completed by health professional

Please answer all questions below:

1. Were you familiar with the patient's medical history prior to this examination? ☐ Yes ☐ No

2. I have attended this patient professionally since: _____ (Month/Year)

Visual Acuity:

☐ Uncorrected			☐ Corrected		
R	L	B	R	L	B
6/	6/	6/	6/	6/	6/

Blood Pressure Reading _____

Other Medical Condition _____

3. Clinical Findings **Please provide where applicable** • details of medical condition • treatments • history of episodes • details of control or complication/s • conditions of licence • results of relevant investigations e.g. Hba1c for diabetes	

4. In my opinion the person who is the subject of this report:

a. ☐ **Meets the relevant medical criteria -** Fit to drive

b. ☐ **Does not meet the relevant medical criteria -** Not fit to drive
Criteria not met - (Please detail relevant clinical findings at question 3)

c. ☐ **Is suitable to drive subject to conditions -** Fit to drive with conditions
(Please enter relevant clinical findings at question 3)
Note: A conditional licence will not be issued unless adequate supporting information is provided by the examining health professional to the relevant department.

5. Requires specialist assessment ☐ Yes ☐ No Please specify _____

☐ **Occupational Therapist assessment (may include driving assessment)**

☐ **On-road practical driving assessment by Department of Transport**

6. Recommended re-assessment period ☐☐ years ☐☐ months

7. I have discussed this recommendation with patient ☐ Yes ☐ No

8. I have examined the patient according to: ☐ **Commercial vehicle standards** **OR** ☐ **Private vehicle standards**
(Heavy vehicle drivers, class MR and above, F extension holders, Taxi drivers, Dangerous goods vehicle driver, Driving Instructors)

DATE OF EXAMINATION	DATE OF REPORT	SURGERY STAMP
REPORTING PROFESSIONAL'S NAME AND QUALIFICATION		

I certify that I have examined the above-mentioned patient in accordance with the relevant National Medical Standards (private or commercial vehicle standards) as set out in *Assessing Fitness to Drive* Guidelines.

TELEPHONE	FAX	SIGNATURE	☐ FURTHER COMMENTS ON MEDICAL CONDITION(S) AFFECTING SAFE DRIVING ARE ATTACHED
EMAIL ADDRESS			