Reset

New Nouveau Brunswick

DEPARTMENT OF PUBLIC SAFETY
MOTOR VEHICLE BRANCH

12231 (3/19)

MEDICAL FITNESS REPORT

* Fee for examination is the responsibility of the licence applicant.

This form is to be completed by a licensed medical practitioner. A positive response must be elaborated upon at the bottom of the form. The physician's stamp must be affixed in the space provided.

Name of applicant _____ Date of Birth _____

Address _____

Licence Number | | | | | | | | Class of licence applied for _____

Does the patient have a history or diagnosis of any of the following:

1. Any loss or impairment of limbs or extremities or other structural defect, limitation of mobility or co-ordination likely to interfere with the safe operation of a motor vehicle? Yes ☐ No ☐
2. Any impairment of the musculo-skeletal or nervous system likely to interfere with the safe operation of a motor vehicle? Yes ☐ No ☐
3. Diabetes mellitus which requires either insulin or oral agents for control? Yes ☐ No ☐
4. Myocardial infarction, angina pectoris, coronary insufficiency or thrombosis? Yes ☐ No ☐
   If first incidence, is the patient fully recovered? Yes ☐ No ☐
5. Heart or lung disease including arrhythmia or respiratory dysfunction? Yes ☐ No ☐
6. Hypertension accompanied by postural hypotension resulting in giddiness when under treatment? Yes ☐ No ☐
7. Requirement for hearing assistance? Yes ☐ No ☐
8. Loss of consciousness or awareness due to a chronic or recurring condition? Yes ☐ No ☐
9. Continuous use of any prescribed drug which could, in the dosage prescribed, impair ability to operate a motor vehicle? Yes ☐ No ☐
10. Clinical diagnosis of alcoholism or drug addiction? Yes ☐ No ☐
11. Established medical evidence of a sustained psychiatric disorder with particular regard to depression, suicidal tendencies or impulsive aggressive behaviour? Yes ☐ No ☐
12. Any other physical or mental impairment, disease or condition which is likely to significantly interfere with the individual's ability to operate a motor vehicle safely? Yes ☐ No ☐

Driver Examiner's Use only

VISION SCREENING

WITHOUT LENSES _____

WITH LENSES _____

EXAMINER _____

AUTHORIZED TRAINING

FOR CLASS _____

UNTIL _____

DD/MM/YY

_____

EXAMINER

DATE _____

VALID FOR N.B., P.E.I., N.S .

Office Stamp

Question	Remarks

This is to certify that I examined the above named applicant on

Date _____

and that this individual has been my patient since

Date _____

Examining Physician Name (Print)

_____

Address _____

_____

Signature X _____

Physician's Stamp

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