

**CONFIDENTIAL MEDICAL / EYE EXAMINATION REPORT**

For confidential use of the DMV in making decisions on the individual's (Named Below) qualifications as a driver. This opinion shall only be divulged to the applicant or driver or in a trial or proceeding concerning the individual's qualifications to receive or retain a driver's license. (Section 42-2-111 and 42-2-112, C.R.S.)

**UNLESS OTHERWISE STATED, THIS REPORT MUST BE RETURNED TO THE OFFICE WHERE INITIAL APPLICATION WAS MADE.**

Date	Office	Office Number	Examiner
Name of Applicant (Print)			Date of Birth
Address			
Current License Number (OPTIONAL)			State

**SECTION I: AUTHORIZATION TO ATTENDING PHYSICIAN/OPTOMETRIST**

TO (Physician/Optomtrist) \_\_\_\_\_

**Note: Physician please complete Sections II and III below. Optometrist please complete Sections IV and V on the reverse side.**

I, \_\_\_\_\_ hereby authorize the above named physician/optometrist to give the Colorado Department of Revenue, or its representative, any information he/she may have regarding my condition when under his/her observation or treatment.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION II: PHYSICIAN'S REPORT OF MEDICAL EXAMINATION**

1. From your assessment of the medical history, physical examination and laboratory data, and in consideration of public safety, would authorization of a driving privilege be medically prudent?  Yes  No Road test required  Yes  No  Rehab Permit Only  
 If it is not prudent to authorize a driving privilege- NO road test will be given .
2. What medical restrictions and/or prostheses are necessary for the above named applicant to operate a motor vehicle? (This approved medical report is contingent upon the following indicated restriction(s) appearing on applicant's instruction permit and/or driver's license. Failure to comply will result in the cancellation and denial of applicant's driving privilege.)

**REMARKS** \_\_\_\_\_  
 \_\_\_\_\_

Physician Name (Please Print): \_\_\_\_\_ Title: \_\_\_\_\_  
 Signatnature \_\_\_\_\_ Current Date of Evaluation: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

**SECTION III: REPORT OF MEDICAL EXAMINATION**

**PHYSICIAN** The information requested herein will be used to evaluate the driving abilities of the applicant. The final determination of this risk, if any, depends on your prompt and accurate completion of this form. **NOTE:** As provided by law, licensed physicians and optometrist are immune from civil and criminal action if they act in good faith and without malice 42-2-112 C.R.S. The physician assumes no responsibility in making this report other than that of representing the facts as they appear from this professional examination. Your medical remarks will be held in confidence.

HEARING (If impaired)	Right Ear	Left Ear	VISION	BLOOD PRESSURE
Whispered voice, standing sideways with distant ear closed.	_____ Ft.	_____ Ft.	Best corrected vision, both eyes open 20/ _____	

No.	Check each item in appropriate column (Enter NE, if not evaluated)	NOR-MAL	AB-NOR-MAL	NOTES Describe every abnormality in detail. Enter applicable item numbers before each comment. Use additional sheet if necessary and attach to this form.
1	HEAD, FACE, NECK			
2	HEART			
3	LUNGS			
4	EXTREMITIES			
5	MUSCULO-SKELETAL			
6	ENDOCRINE Diabetes			
7	NEUROLOGIC			
8	PSYCHIATRIC Serious Neurosis Psychosis Serious Personality Deviation			
9	OTHER			

- 10 Does history indicate seizures or lapses of consciousness?  Yes  No If yes, continue to complete question No. 11
- 11 Date of onset \_\_\_\_\_ Frequency \_\_\_\_\_ Dates of last two seizures or lapses \_\_\_\_\_
- Describe any seizures/lapses of consciousness \_\_\_\_\_
- Probable diagnosis \_\_\_\_\_

**SECTION IV: EYE EXAMINATION REPORT**

1. From your assessment of the visual history, visual examination and laboratory data, and in consideration of public safety, would authorization of a driving privilege be medically prudent?  Yes  No  
 If it is not prudent to authorize a driving privilege, NO road test will be given.  
 Road test Required?  Yes  No

**Special Restrictions:**  Daylight driving only.  Area Radius \_\_\_\_\_ Miles from home  
 Not more than \_\_\_\_\_ MPH  Right Sideview Mirror  Left Sideview Mirror  
 Other \_\_\_\_\_

Optometrist's Name (Please Print): \_\_\_\_\_ Title: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date of Evaluation: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**SECTION V: REPORT ON EXAMINATION OF EYE CONDITION**

ACUITY (Check appropriate boxes)	Both	Right	Left
Without Correction	20/ _____	20/ _____	20/ _____
With Glasses	20/ _____	20/ _____	20/ _____
With Contact Lenses	20/ _____	20/ _____	20/ _____
Bioptic Lenses	20/ _____	20/ _____	20/ _____
Carrier Lens	20/ _____	20/ _____	20/ _____

COORDINATION: PHORIAS (To be measured at 20 feet)  
 Horizontal Exo \_\_\_\_\_ Eso \_\_\_\_\_  
 Vertical: R Hyper \_\_\_\_\_ L Hyper \_\_\_\_\_  
 FUSION:  Excellent  Good  Poor  None  
 DEPTH PERCEPTION:  Excellent  Good  Poor  None

FIELDS - HORIZONTAL PERCEPTION FIELDS:  Pass  Deficient  Fail  
 RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

COLOR: Traffic Lights, Holmgren, Ishihara, Edrige, Nagel, or  
 Other \_\_\_\_\_

RESPONSE TO LIGHT: (Please furnish if testing equipment is available)  
 Pupillary reflex Right \_\_\_\_\_ Left \_\_\_\_\_  
 Glare resistance Right \_\_\_\_\_ Left \_\_\_\_\_  
 Glare recovery Right \_\_\_\_\_ Left \_\_\_\_\_

INJURY OR DISEASE  
 (Please describe fully)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I understand that this form will be considered in any decision regarding the issuance of my driver's license.

Signature: \_\_\_\_\_ Date \_\_\_\_\_