



Robert Hauser

Evaluating Medical Conditions or Disabilities

Welcome to the module discussing evaluating medical conditions or disabilities.

While reading the information contained in this module, here are a few of the items you will want to review:

- Learn the proper medical evaluation forms
- Become familiar with how medical conditions can affect driving tasks
- Discover your role in determining when a medical form is issued
- Learn when to recommend a special exam
- VTS (Voluntary Temporary Surrender) Procedures


At the end of this module there will be a short quiz:

- **You must get 100% correct in order to complete the module**
- In addition to this module, you may use [Knowledge Owl](#) and/or your notes to assist in finding the correct answers

Click on the "Start Course" button above to start this course.

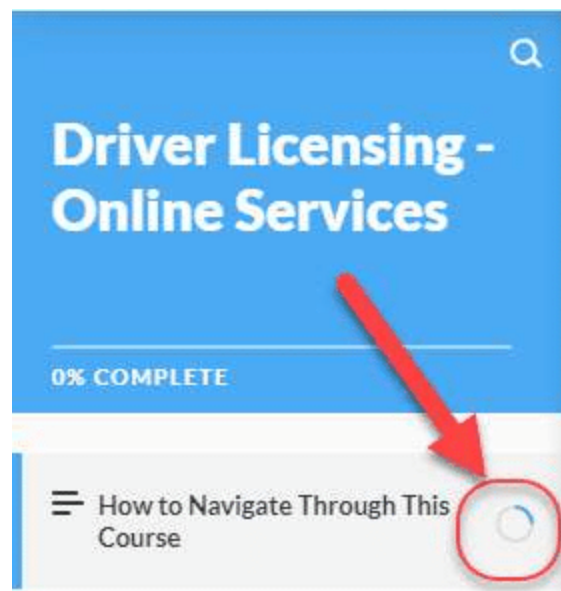


How to Navigate Through This Course

- ≡ Confidentiality
- ≡ MV3141 - Driver Condition or Behavior Report
- ≡ MV3454 Pledge of Confidentiality
- ≡ Evaluating Drivers/Issuing Medical Reports
- ≡ Ability/Standard
- ≡ Guidelines
- ≡ Special Exams
- ≡ Denials
- ≡ Voluntary Temporary Surrender (VTS)
-  Quiz
- ≡ Questions

How to Navigate Through This Course

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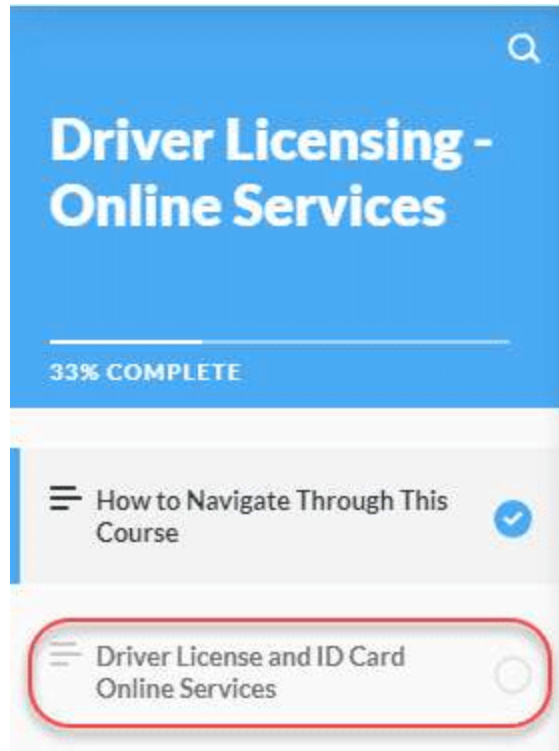


This training contains lessons. Each lesson has its own page. As you move down in each lesson, a status circle will begin to fill in the closer you get to the end of that lesson.

Lesson 2 - Driver License and ID Card Online Services



Once the bottom of the page is reached, a bar will display at the very bottom of the course letting you select the Next Lesson, or:



You can also select the next lesson in the status bar on the left side of the window. You must complete one lesson before you can move to the next.



To enlarge a photo, click on the picture. To return to the training, click again.

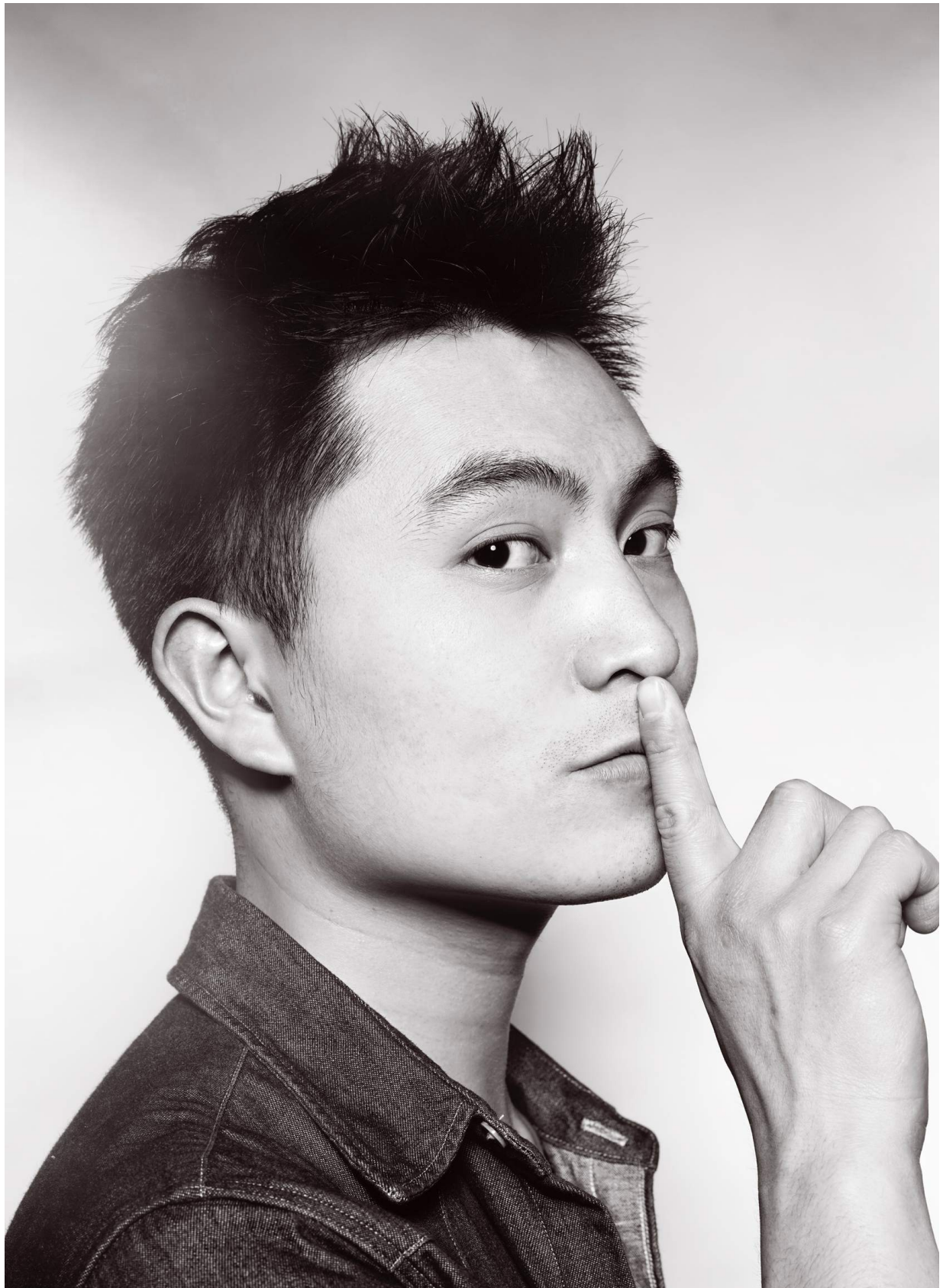
Lesson 2 of 12

Confidentiality



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Information submitted by an individual about his/her medical condition is treated as confidential information

Medical information can not be released by anyone, unless the department has written permission from the individual who is the subject of the report:

- Refer the customer to the Medical Review and Fitness Unit (MRF)
- **BFS never releases information at the counter**

MV3141 - Driver Condition or Behavior Report

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Positive identification of the person being reported must be established. Further investigation by the Medical Review and Fitness Unit (MRF) may be necessary

No action is taken on anonymous reports or reports that only give a license plate number

All driver condition or behavior reports must be referred to the Medical Review and Fitness Unit (MRF)



Civil Liability

Physicians (MD/DO) or advanced practice nurse prescribers (APNP) reporting a drivers condition in good faith are protected from civil liability under Statute 448.08(5)

Refer any inquires to the Medical Review and Fitness Unit (MRF)



DRIVER CONDITION OR BEHAVIOR REPORT

Wisconsin Department of Transportation
MV3141 8/2017



LAW ENFORCEMENT OR PRIVATE CITIZEN Complete this side only

The following information is submitted for consideration as "Good Cause" for Departmental action as authorized under section 343.16 Wisconsin Statutes. Advanced age alone, cannot be considered as good cause. **Positive driver identification must be established.** License plate number only is not sufficient.

This information may be subject to Wisconsin's Open Records Law.

Submit to:

Wisconsin Department of Transportation
Medical Review
P.O. Box 7918
Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

Driver Name – First, Middle, Last		Birth Date	
<input type="text"/>		<input type="text"/>	
Driver License Number	State of Issuance		
<input type="text"/>	<input type="text"/>		
Address, City, State, ZIP Code			
<input type="text"/>			
Driver Condition – Check appropriate boxes. Describe below.			
<input type="checkbox"/> Physical Condition		<input type="checkbox"/> Confused/Disoriented	
<input type="checkbox"/> Mental/Emotional Condition		<input type="checkbox"/> Alcohol/Other Drugs	
<input type="checkbox"/> Blackout, Seizure, Fainting Spell		<input type="checkbox"/> Defective Vision	
<input type="checkbox"/> Lack of Knowledge of Traffic Laws		<input type="checkbox"/> Obstructing Traffic	
Type of Enforcement Action Taken	Incident Date	Time	Report Date (m/d/yy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Describe in detail incidents or conditions, which brought this driver to your attention. Give specific information such as dates, places, accident reports, were Emergency Medical Personnel at the scene and all other available information to support the Department's action. DMV will not accept hearsay or second-hand information.			
<input type="text"/>			
Print Name		(Area Code) Telephone Number	
<input type="text"/>		<input type="text"/>	
Address, City, State, ZIP Code			
<input type="text"/>		<input type="text"/>	
		X (Signature) (Date m/d/yy)	
If this report is being completed by private citizens or family members, the full name, address and signature of a second or additional person who can verify the above information is REQUIRED. A signature verifies the information to be true and correct.			
Print Name		(Area Code) Telephone Number	
<input type="text"/>		<input type="text"/>	
Address, City, State, ZIP Code			
<input type="text"/>		<input type="text"/>	
		X (Signature) (Date m/d/yy)	



DRIVER CONDITION OR BEHAVIOR REPORT

Wisconsin Department of Transportation
MV3141 8/2017



HEALTH CARE PROFESSIONAL ONLY

Only MD, DO, OD, PA-C or APNP complete this side

This information is not subject to Wisconsin's Open Records Law; it is, however, available to the driver upon request.

Driver Name – First, Middle, Last	Birth Date

Driver License Number	State of Issuance	Date of Examination

Address, City, State, ZIP Code

Describe in detail patient's current medical condition(s) and diagnosis. Give specific information to support the Department's action.

--

- | YES | NO | |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is this patient able to safely operate a motor vehicle at this time?
A "No" answer will result in immediate cancellation of all license classes and endorsements.
The department cannot test a person who is deemed medically unsafe. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. If the answer to #1 is "Yes", do you recommend a complete re-examination of patient's driving ability (knowledge, sign and skills tests)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. If the answer to #1 is "Yes," do you recommend that the driver's license be restricted? Check all that apply.
<input type="checkbox"/> Continuous oxygen use
<input type="checkbox"/> Daylight driving only
<input type="checkbox"/> Drive only _____ miles from home
<input type="checkbox"/> No freeway or interstate highway
<input type="checkbox"/> Corrective lenses |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you recommend any additional medical evaluation? |

Print Name	Medical License Number	(Area Code) Telephone Number
Mailing Address, City, State, ZIP Code	Signature of MD, DO, OD, PA-C or APNP	
	X	
	(Signature)	(Date m/d/yy)

MV3454 Pledge of Confidentiality



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Customers volunteering information about other licensed drivers should be told that the information will be available to the driver they are reporting under Wisconsin Open Records law

- This does not include unsolicited reports from physicians and optometrists

Do not volunteer information regarding the pledge of confidentiality (MV3454) unless the customer initiates or requests to remain anonymous **before** identifying the driver



If the person is not willing to provide the information without a pledge of confidentiality and the information is not available through other sources, use the pledge form

A pledge of confidentiality (MV3454) can not be given after an individual has provided identifying information for the driver being reported



PLEDGE OF CONFIDENTIALITY
MV3454 1/2013 343.16(5)(d) Wis. Stats.

Wisconsin Department of Transportation • Medical Review
PO Box 7918, Madison, WI 53707-7918
Telephone: (800) 266-2327
FAX: (800) 267-0518
Email: dmvmedical@dot.wi.gov

Completion of this Pledge of Confidentiality indicates that you have information which questions a person's ability to safely operate a motor vehicle. It also indicates that you will not disclose the information to the Wisconsin Department of Transportation (WisDOT), including the driver's name, without a Pledge of Confidentiality. This pledge will remain confidential to the extent permitted by law. A court of competent jurisdiction could order the release of information otherwise held in confidence as a result of this pledge.

To be valid, this Pledge must be signed by a Wisconsin Department of Transportation representative prior to receiving the personally identifiable information about the driver. **Information provided prior to completion of this Pledge, or not listed in this Pledge, or any subsequent information that is not identified in a Pledge of Confidentiality Agreement will not be considered confidential.**

SECTION 1 – To be completed by the Information Source

Name of Information Source (First, Middle Initial, Last)	Address		
(Area Code) Telephone Number	City	State	ZIP Code

Please give the reason the information will not be provided without a *Pledge of Confidentiality*:

X

(Information Source Signature)

(Date – m/d/yy)

SECTION 2 – To be completed by a WisDOT Representative

I have determined that a *Pledge of Confidentiality* is necessary to obtain potentially important information related to public safety. I extend the Department's Pledge to the above-named information source.

X

(WisDOT Representative Signature)

(Date – m/d/yy)

SECTION 3 – To be completed after the pledge is signed by a WisDOT Representative

Name of Driver (First, Middle Initial, Last)			
Address			
City	State	ZIP Code	Driver Identification Number

SECTION 4 – Form MV3141, *Driver Condition or Behavior Report* MUST be attached.

See: <http://wisconsindot.gov/Pages/dmv/license-drivers/rcd-crsh-rpt/driver-forms.aspx>

Evaluating Drivers/Issuing Medical Reports



DMV staff have the responsibility to determine whether the functional ability of a customer may interfere with their ability to exercise ordinary and reasonable control in the operation of a motor vehicle

The responsibility is the same regardless of the classes or endorsements the customer holds

Staff have 4 sources of information to alert them to a potential medical problem or disability...

The Medical Review and Fitness Unit (MRF) is available to assist in making these determinations. Click below to view the different sources:

Source 1

WISCONSIN DRIVER LICENSE (DL) APPLICATION

Wisconsin Department of Transportation MV3001 9/2017 Ch. 343 Wis. Stats.

Clear Form

Print

ALL APPLICANTS – Please Print

Social Security Number		Applicant Name – First, Middle, Last			Birth Date (mm/dd/yyyy)	
Residence Address – Street		Apt #	City	State	ZIP Code	County of Residence
Mailing Address – ONLY IF DIFFERENT from Residence		Apt #	City	State	ZIP Code	County of Residence
Sex	Race	Eyes	Hair	Weight	Height	
Former Name (If changed since last license or ID card)			Reason for Name Change Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other <input type="checkbox"/> List: _____			

1. Do you wish to register to be an organ, tissue and eye donor? YES <input type="checkbox"/>	7. Do you need glasses or contact lenses for driving? YES <input type="checkbox"/> NO <input type="checkbox"/>
2. OPT OUT – Do you wish to have your name and address withheld from lists WisDOT sells? YES <input type="checkbox"/>	8. Are you missing a limb? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. I am a veteran registered with WDVA and wish to have my veteran status indicated on my driver license. (DMV is required to verify your status with WDVA) YES <input type="checkbox"/>	If yes, have you successfully passed a road test with this condition? YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Has your license, ID card or operating privilege ever been revoked, suspended, cancelled, disqualified or denied? If yes, list date and place: _____ YES <input type="checkbox"/> NO <input type="checkbox"/>	9. In the past year have you had a loss of consciousness or muscle control caused by any of the following conditions? If yes, check condition(s) and list date(s): _____ YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Have you been convicted of operating while intoxicated OUTSIDE of Wisconsin? If yes, give date and place: _____ YES <input type="checkbox"/> NO <input type="checkbox"/>	Traumatic Brain or Head Injury (2) <input type="checkbox"/> Muscle or Nerve (2) <input type="checkbox"/> Seizure Disorder (4) <input type="checkbox"/> Heart (5) <input type="checkbox"/> Stroke (2) <input type="checkbox"/> Mental (3) <input type="checkbox"/> Diabetes (5) <input type="checkbox"/> Lung (7) <input type="checkbox"/>
6. Do you hold a valid driver license/identification card from another state/country? If yes, list: _____ YES <input type="checkbox"/> NO <input type="checkbox"/>	10. Check ONLY ONE of the following three boxes. I certify that I am a: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Temporary Visitor <input type="checkbox"/> Permanent or Conditional Permanent Resident
Years of licensed driving experience in the United States, its territories and Canada. List: _____	11. Will you donate \$2 to organ, tissue and eye donation efforts? YES <input type="checkbox"/>

I understand that I must surrender for cancellation any driver license or identification card previously issued by another state before I may be issued a driver license or identification card in the State of Wisconsin. The State of Wisconsin will notify the other state that my driver license or identification card is surrendered and cancelled, and that I have been issued a Wisconsin license or identification card. (ss. 343.11(1) and (2), and 343.50(1)(b) Wis. Stats.) I certify that the information on this application is true under penalty of perjury and I am a resident of Wisconsin. (s. 343.14(5) Wis. Stats.)

X

(Applicant Signature)

(Date)

OFFICE USE ONLY

Date	Processor ID	Reason for Reissue:		Product Type
Wisconsin or Out-of-State License Number	State	Expiration Date	<input type="checkbox"/> REAL ID	<input type="checkbox"/> REGI <input type="checkbox"/> CLP <input type="checkbox"/> CYCI <input type="checkbox"/> SPRI <input type="checkbox"/> JUVI <input type="checkbox"/> MPDI <input type="checkbox"/> PROB <input type="checkbox"/> RGLR <input type="checkbox"/> OCCL <input type="checkbox"/> SPRR <input type="checkbox"/> JUVF <input type="checkbox"/> NON
Hearing (CDL Only)	Examiner ID	Application Type		Class(es) Issued
Skill Test Score	Highway Signs	Knowledge	<input type="checkbox"/> ORG <input type="checkbox"/> RNW <input type="checkbox"/> DUP <input type="checkbox"/> REI <input type="checkbox"/> RSM <input type="checkbox"/> AMD <input type="checkbox"/> COA	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> M
Federal Medical Certificate Shown		Endorsements		
<input type="checkbox"/> NO <input type="checkbox"/> YES; Expires: _____		<input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T <input type="checkbox"/> F		
Payment		Amount		
<input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> CC <input type="checkbox"/> Acct.		\$		

VISION

<input type="checkbox"/> Check if vision section completed by DMV Examiner			
Visual Acuity	Without RX	With RX	Temporal Field of Vision In Degrees
Right Eye	20/	20/	
Left Eye	20/	20/	
Corrective lenses required while driving <input type="checkbox"/> YES <input type="checkbox"/> NO			
Color Perception <input type="checkbox"/> Normal <input type="checkbox"/> Deficient			
Progressive eye disease or cataracts <input type="checkbox"/> YES <input type="checkbox"/> NO			
If Yes, to Progressive eye disease or cataracts <input type="checkbox"/> One Eye <input type="checkbox"/> Both Eyes			
I certify that the findings are correct and I examined this applicant on: _____ (Exam Date)			
X (Eye Examiner Signature)			
(License #)			

Source 1:**Information on the application (MV3001)**

Customer may answer "Yes" to a medical condition:

- Customer should only answer "Yes" to a medical condition if they have had an episode of altered consciousness or loss of bodily control in the last 12 months
- If the customer is uncertain how to answer, it may be necessary for them to describe symptoms, this should be done in as private a manner as possible

Source 2




Source 2:

Information given during a conversation with a customer

Customer may indicate in conversation that there is a medical problem

Source 3



State of Wisconsin
 Department of Transportation

Navigation Links

User
 Preferences
 Log Off

Inquiry System - Query Input

Search by:

Drivers General Input
 FEIN
 Incident Case Number
 Incident Number
 Legal Presence Number
 NSD ID
 Name, Sex, DOB
 Non-Uniform Traffic Citation Nb
 Payment Number
 Plate

Results Report Style:

Customer Details
 Customer History
 Disabled Id Details
 Disabled Id History
 Driver Detail History Report
 Driver Detail No History Report
 Financial Report
 Vehicle Summary

NSD ID*

Or

SSN*

Or

First name*

Middle name

Last name*

Suffix

Sex
 ☐

DOB

(M/F) (MMDDYYYY)

☒ Show only primary records

* indicates required

Source 3:

Information from the customers driving record

The customers record may show:

- A medical correspondence entry
- A product notation

Source 4



Source 4:

Observation

DMV staff will observe the customer as they walk to the counter, and while serving the customer to determine if the customer has the functional ability to perform normal tasks required to exercise ordinary and reasonable control in the safe operation of a motor vehicle

- Persons not meeting these standards and whose license is not properly restricted are required to submit to a Special Exam of their driving ability, file a medical report, or both

Ability/Standard

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Click below to view the ability and standards:

Lower Body Strength



Ability - Lower body strength

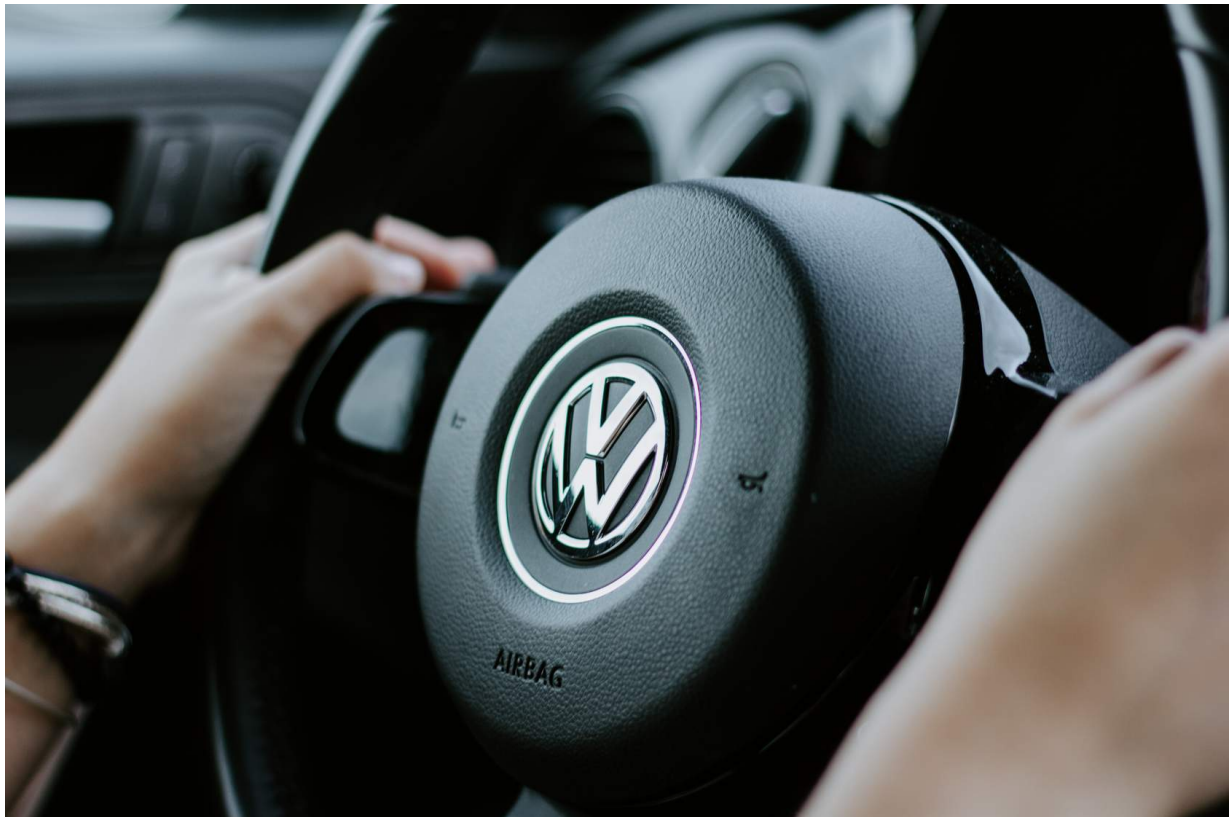
Range of motion, mobility and coordination to use foot operated vehicle controls

Standard:

Person is able to walk to a DMV service center counter unaided physically by another person or significant support device

- There is no loss (full or partial) of a leg or foot
- No excessive shaking, tremor, weakness, rigidity or paralysis

Upper Body Strength



Ability - Upper body strength

Range of motion and coordination to use hand operated controls and to turn the head and body to the left, right or rear to observe other traffic or pedestrians

Standard:

Person is able to turn the head and upper body to the left and right, has full use of the arms and hands. There is no loss (full or partial) of an arm. There is no loss of a hand or finger which interferes with proper grasping. No excessive shaking, tremor, weakness, rigidity or paralysis

Sight



Ability - Sight

The ability to see other traffic, road conditions, pedestrians, traffic signs and signals

Standard:

Person is able to meet applicable vision requirements by passing a DMV vision screening or presenting evidence of similar testing by a vision specialist

Cognitive Skills**Ability - Cognitive Skills**

To think, understand, perceive and remember

Standard:

Person exhibits cognitive skills. Responds to questions and instructions. No obvious disorientation

- Able to complete application, knowledge test or vision screening

Consciousness/Bodily Control



Ability - Consciousness/Bodily Control

The ability to maintain normal consciousness and bodily control

- Ability to respond to stimuli

Standard:

Person exhibits normal consciousness and bodily control

- No self disclosed or obvious incident or segment of time involving altered consciousness
- No loss of body control involving involuntary movements of the body, muscle spasms or muscle rigidity, loss of tone or movement
- No obvious disorientation
- Is able to complete an application, knowledge test or vision screening

State of Mind



Ability - State of mind

The ability to maintain a normal social, mental or emotional state of mind

Standard:

Person does not exhibit an extremely hostile and/or disruptive, aggressive behavior or being out of control. No obvious disorientation

Additional Information

After considering these sources of information, if there is a good reason to believe a functional impairment exists that may impair driving, additional questions may be necessary.

The Medical Review and Fitness Unit (MRF) is always available to assist!

Guidelines



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Whenever possible, take the customer aside to discuss personal information such as the status of a medical condition

If it is not possible to talk privately, try to create as private of a setting as possible:

- Talk quietly
- Explain that you need to ask a few questions about their condition to assess how it may affect driving

Questions to Ask

Here are some sample questions you may need to ask your customer:

☐

It appears you have a medical or physical condition, is it progressive or temporary?

☐

It appears you have a medical or physical condition, are you receiving treatment for it?

If yes, what treatment:

Medication

Counseling

☐

I see you need assistance and/or use a wheelchair/ walker, etc. Do you have a medical condition that is progressive or is it a permanent disability? Are you receiving treatment for it?

MS

Parkinson's

Amputations

Arthritis

Consciousness

MEDICAL EXAMINATION REPORT

MV3644 1/2013 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

Clear Form

Wisconsin Department of Transportation
Medical Review
PO Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

APPLICANT: After this medical report has been reviewed, you may be required to file medical reports on a regular basis. We will send you the forms at the time they are required.

Applicant Name		Operator License Number	
Street Address		Birth Date (m/d/yyyy)	
City, State, ZIP Code		(Area Code) Telephone Number	
Date Report Issued (m/d/yyyy)	WisDOT Examiner Badge Number	License Type	<input type="checkbox"/> CDLI <input type="checkbox"/> Passenger Bus <input type="checkbox"/> Instruction Permit <input type="checkbox"/> Operator <input type="checkbox"/> CDL <input type="checkbox"/> School Bus
Reason for Referral			

HEALTH CARE PROFESSIONAL: Please complete all pertinent sections relative to this person's health to assist the Department in making a licensing decision.

- ☐ Driver Condition or Behavior Report Attached. Driving Incident/Accident Date(s):
- ☐ General Medical: complete sections A and G (others if appropriate)
- ☐ Mental / Emotional: complete sections A, B, and G
- ☐ Neurological: complete sections A, C, and G
- ☐ Endocrine (Diabetes): complete sections A, D, and G
- ☐ Cardiovascular: complete sections A, E, and G
- ☐ Pulmonary: complete sections A, F, and G

SECTION A HEALTH CARE PROFESSIONAL - To Complete for ALL Applicants

Provide Diagnoses, Medications Used, and Dosages:

	Height
	Weight

YES NO

- ☐ ☐ 1. Is the person's condition currently stable? If not, explain below.
- ☐ ☐ 2. Is the person reliable in following the treatment program? If not, explain below.
- ☐ ☐ 3. Does this person experience side effects of medication which are likely to impair driving ability? If yes, explain below.
- ☐ ☐ 4. Has this person experienced an episode of altered consciousness or loss of bodily control during the past 12 months? If yes, explain below and give date.
- ☐ ☐ 5. Does current alcohol/drug abuse/use interfere with medical condition? If yes, a substance evaluation will be required.
- ☐ ☐ a. Did the person have a seizure(s) related to withdrawal? If yes, explain below and give date.
- ☐ ☐ 6. Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy, or other disorder? If yes, explain below.
- ☐ ☐ 7. Is driving ability likely to be impaired by limitations in any of the following?
- ☐ ☐ a. Judgment and insight
- ☐ ☐ b. Problem-solving and decision-making
- ☐ ☐ c. Emotional or behavioral stability
- ☐ ☐ d. Cognitive function or memory loss
- ☐ ☐ 8. Is driving ability likely to be impaired by limitations in any of the following?
- ☐ ☐ a. Reaction time
- ☐ ☐ b. Sensorimotor function
- ☐ ☐ c. Strength and endurance
- ☐ ☐ d. Range of motion
- ☐ ☐ e. Maneuvering skills
- ☐ ☐ f. Use of arm(s) and/or leg(s)

Details and Elaboration

If a customer has an episode of altered consciousness or loss of bodily control caused by a neurological condition within the last 3 months, the driver is not eligible for a license and

should be encouraged to surrender their license

Regardless of whether or not the customer surrenders, issue the medical report and notify the Medical Review and Fitness Unit (MRF)

(In Knowledge Owl: Search 235 Summary & Table of Contents, for procedure)

Special Exams

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A complete Special Exam will be required if a customer, including an out of state transfer, does not meet DMV standards for Functional Ability, and their license is not restricted appropriately for the disability

If you are unsure about whether or not to require tests, consult with your teamlead, supervisor, co-worker or the Medical Review and Fitness Unit (MRF)

Never issue a medical report just to see if a physician will recommend tests. A doctor visit costs the customer money and time, and it is our responsibility to determine if the customer needs to be tested

[More Information](#)



DRIVER CONDITION OR BEHAVIOR REPORT

Wisconsin Department of Transportation
MV3141 8/2017



HEALTH CARE PROFESSIONAL ONLY

Only MD, DO, OD, PA-C or APNP complete this side.

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Driver Name – First, Middle, Last		Birth Date	
<input type="text"/>		<input type="text"/>	
Driver License Number	State of Issuance	Date of Examination	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address, City, State, ZIP Code			
<input type="text"/>			

Describe in detail patient's current medical condition(s) and diagnosis. Give specific information to support the Department's action.

- | YES | NO | |
|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is this patient able to safely operate a motor vehicle at this time?
A "No" answer will result in immediate cancellation of all license classes and endorsements.
The department cannot test a person who is deemed medically unsafe. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. If the answer to #1 is "Yes", do you recommend a complete re-examination of patient's driving ability (knowledge, sign and skills tests)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. If the answer to #1 is "Yes," do you recommend that the driver's license be restricted? Check all that apply.
<input type="checkbox"/> Continuous oxygen use
<input type="checkbox"/> Daylight driving only
<input type="checkbox"/> Drive only <input type="text"/> miles from home
<input type="checkbox"/> No freeway or interstate highway
<input type="checkbox"/> Corrective lenses |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you recommend any additional medical evaluation? |

Print Name	Medical License Number	(Area Code) Telephone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address, City, State, ZIP Code		Signature of MD, DO, OD, PA-C or APNP
<input type="text"/>		<input type="text"/>
		X (Signature) (Date m/d/yy)

MEDICAL EXAMINATION REPORT

MV3644 1/2013 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

Clear Form

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Street Address		Birth Date (m/d/yyyy)	
City, State, ZIP Code		(Area Code) Telephone Number	
Date Report Issued (m/d/yyyy)	WisDOT Examiner Badge Number	License Type <input type="checkbox"/> Instruction Permit	<input type="checkbox"/> CDLI <input type="checkbox"/> Operator <input type="checkbox"/> Passenger Bus <input type="checkbox"/> CDL <input type="checkbox"/> School Bus
Reason for Referral			

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- ☐ Cardiovascular: complete sections A, E, and G
- ☐ Pulmonary: complete sections A, F, and G

SECTION A - HEALTH CARE PROFESSIONAL - To Complete for ALL Applicants

Provide Diagnoses, Medications Used, and Dosages:

	Height
	Weight

YES NO

- ☐ ☐ 1. Is the person's condition currently stable? If not, explain below.
- ☐ ☐ 2. Is the person reliable in following the treatment program? If not, explain below.
- ☐ ☐ 3. Does this person experience side effects of medication which are likely to impair driving ability? If yes, explain below.
- ☐ ☐ 4. Has this person experienced an episode of altered consciousness or loss of bodily control during the past 12 months? If yes, explain below and give date.
- ☐ ☐ 5. Does current alcohol/drug abuse/use interfere with medical condition? If yes, a substance evaluation will be required.
- ☐ ☐ a. Did the person have a seizure(s) related to withdrawal? If yes, explain below and give date.
- ☐ ☐ 6. Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy, or other disorder? If yes, explain below.
- ☐ ☐ 7. Is driving ability likely to be impaired by limitations in any of the following?
- ☐ ☐ a. Judgment and insight
- ☐ ☐ b. Problem-solving and decision-making
- ☐ ☐ c. Emotional or behavioral stability
- ☐ ☐ d. Cognitive function or memory loss
- ☐ ☐ 8. Is driving ability likely to be impaired by limitations in any of the following?
- ☐ ☐ a. Reaction time
- ☐ ☐ b. Sensorimotor function
- ☐ ☐ c. Strength and endurance
- ☐ ☐ d. Range of motion
- ☐ ☐ e. Maneuvering skills
- ☐ ☐ f. Use of arm(s) and/or leg(s)

Details and Elaboration

A special exam can be generated for customers with a physical/functional impairments as a result of a Driver Condition Report (MV3141) or a Medical Report (MV3644) questioning the drivers ability to safely operate a motor vehicle

Note - Temporary physical/functional impairments such as broken limbs do not required a special exam

Special Exam - Refusal





If a customer appears to be a safety risk and refuses to complete a special exam, contact the Medical Review and Fitness Unit (MRF) to discuss appropriate action

Consciousness

MEDICAL EXAMINATION REPORT

MV3644 1/2013 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

Clear Form

Wisconsin Department of Transportation
Medical Review
PO Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmrmedical@dot.wi.gov

APPLICANT: After this medical report has been reviewed, you may be required to file medical reports on a regular basis. We will send you the forms at the time they are required.

Applicant Name		Operator License Number	
Street Address		Birth Date (m/d/yyyy)	
City, State, ZIP Code		(Area Code) Telephone Number	
Date Report Issued (m/d/yyyy)	WisDOT Examiner Badge Number	License Type <input type="checkbox"/> Instruction Permit	<input type="checkbox"/> CDLI <input type="checkbox"/> Operator <input type="checkbox"/> Passenger Bus <input type="checkbox"/> CDL <input type="checkbox"/> School Bus
Reason for Referral			

HEALTH CARE PROFESSIONAL: Please complete all pertinent sections relative to this person's health to assist the Department in making a licensing decision.

- ☐ Driver Condition or Behavior Report Attached. Driving Incident/Accident Date(s):
- ☐ General Medical: complete sections A and G (others if appropriate)
- ☐ Mental / Emotional: complete sections A, B, and G
- ☐ Neurological: complete sections A, C, and G
- ☐ Endocrine (Diabetes): complete sections A, D, and G
- ☐ Cardiovascular: complete sections A, E, and G
- ☐ Pulmonary: complete sections A, F, and G

SECTION A HEALTH CARE PROFESSIONAL - To Complete for ALL Applicants

Provide Diagnoses, Medications Used, and Dosages:

	Height
	Weight

YES NO

- ☐ ☐ 1. Is the person's condition currently stable? If not, explain below.
- ☐ ☐ 2. Is the person reliable in following the treatment program? If not, explain below.
- ☐ ☐ 3. Does this person experience side effects of medication which are likely to impair driving ability? If yes, explain below.
- ☐ ☐ 4. Has this person experienced an episode of altered consciousness or loss of bodily control during the past 12 months? If yes, explain below and give date.
- ☐ ☐ 5. Does current alcohol/drug abuse/use interfere with medical condition? If yes, a substance evaluation will be required.
- ☐ ☐ a. Did the person have a seizure(s) related to withdrawal? If yes, explain below and give date.
- ☐ ☐ 6. Does this person experience uncontrolled sleepiness associated with sleep apnea, narcolepsy, or other disorder? If yes, explain below.
- ☐ ☐ 7. Is driving ability likely to be impaired by limitations in any of the following?
- ☐ ☐ a. Judgment and insight
- ☐ ☐ b. Problem-solving and decision-making
- ☐ ☐ c. Emotional or behavioral stability
- ☐ ☐ d. Cognitive function or memory loss
- ☐ ☐ 8. Is driving ability likely to be impaired by limitations in any of the following?
- ☐ ☐ a. Reaction time
- ☐ ☐ b. Sensorimotor function
- ☐ ☐ c. Strength and endurance
- ☐ ☐ d. Range of motion
- ☐ ☐ e. Maneuvering skills
- ☐ ☐ f. Use of arm(s) and/or leg(s)

Details and Elaboration

If the customer appears to be experiencing obvious symptoms of altered consciousness or loss of body control, a medical report will be needed in addition to the special exam

Do not conduct a special exam prior to obtaining an approved medical report

If a physician or advanced practice nurse does not recommend a special exam, you should assess the customer to determine if one is needed

Restrictions



Place restrictions on customer's license if necessary

- They could be the result of a physicians or advance practice nurse recommendation or a skills test
- Restrictions such as steering knob or automatic transmission, are placed on a license where there is a demonstrated need for these restrictions
 - Driver must be given the skills test with the adaptive equipment on the vehicle

A test using a brake reactor or other methods is not a substitute for a special exam!

Denials

RH Robert Hauser



No license should be denied in the field for a medical reason. Denials must be handled by the Medical Review and Fitness Unit (MRF), so each customer is advised in writing of the specific reason for denial, and of the opportunity for a board review

- Remember, BFS staff defer licensing

Voluntary Temporary Surrender (VTS)



Customers may choose to Voluntarily Surrender (VTS) the license instead of taking tests or filing a medical report

If the highway signs, knowledge or skills test is attempted and failed, the customer may choose to VTS the license

- If the customer does not voluntarily surrender, a cancellation for unsuccessful exam will be entered

VOLUNTARY TEMPORARY SURRENDER OF LICENSE
 Wisconsin Department of Transportation
 MV3581 5/2017 s.343.285(1m) Wis. Stats.

Driver Name _____

Driver License Number _____

I volunteer to surrender my:
☐ CLS – Class(es) and Endorsement(s)
☐ EDT – Endorsement Only
 Because of:
☐ INS – Financial responsibility only, SR22
☐ RLP – Medical reason is: _____
☐ Other: _____

Check all classes and/or endorsements affected by the voluntary surrender:
 Classes: ☐ A ☐ B ☐ C ☐ D ☐ M
 Endorsements: ☐ F ☐ H ☐ N ☐ P ☐ S ☐ T

If you wish to surrender any or all of your driving privileges, you **MUST** sign and date this form. You may need to fulfill additional medical, knowledge or skills exam requirements to regain the surrendered classes and/or endorsements. *POA see other side for instructions.

X _____ (Date) _____
 (Driver Signature)

If the customer chooses to voluntarily surrender, pick of the license and have the customer complete an MV3581 (Voluntary Temporary Surrender of License) form, and indicate on the form the date and time of the surrender

Customer is eligible for a free ID card

Customer must complete and sign the MV3581. Only the customer or their Power of Attorney (POA) or guardian may sign the form

- If POA or guardianship is granted to another
 - Proof of POA/guardian is required
- All POA/guardianship must be emailed to and approved by the Medical Review and Fitness Unit (MRF)
- Enter VTS on system using the RLP charge code for medical

Quiz



Robert Hauser

Next you will be taking a quiz. In addition to this module, you may use Knowledge Owl, and/or your notes to assist you:

To open Knowledge Owl, click here: [Knowledge Owl](#)

In Knowledge Owl, search: **235 Summary & Table of Contents**

You must get 100% correct for the module to complete

Question

01/05

DMV staff have four sources of information to alert them of customer's potential medical or physical problem.

Select all that apply:

☐

Customers application

☐

Conversation with the customer

☐

Customers driving record

☐

Observing the customer

☐

Knowledge Owl

☐

SR22

☐

Fed Med Card

Question

02/05

What is form MV3644 used for?

- ☐ General medical
- ☐ Eye Exams
- ☐ CDL Physicals

Question

03/05

Means the degree of cognitive, mental or emotional, sensorimotor and sensory capability in performing activities of daily living, including safely performing the tasks of driving. May require a re-evaluation of their driving ability, a medical exam report, or both requirements to assess

- ☐ Functional Ability
- ☐ Medical Condition
- ☐ Altered Consciousness

Question

04/05

Means any physical, mental or emotional condition which affects a person's health for which a person is receiving medical treatment, or for which medical treatment is usually prescribed.

- ☐ Functional ability
- ☐ Medical conditions
- ☐ Altered consciousness

Question

05/05

Means a state of awareness characterized by loss or distortion of the impressions made by the senses or inability to respond to the impressions made by the senses. (Examples: prolonged dizziness, fainting, syncope, seizure, hallucinations, vertigo or blackout.)

- ☐ Functional ability
- ☐ Medical conditions
- ☐ Altered consciousness

Questions

 Robert Hauser



Questions?

Check with your Station Trainer, Team Lead or Supervisor.