Division of Vehicles
Driver Solutions/Medical & Vision Unit
PO Box 2188
Topeka KS 66601-2188

Kansas
Department of Revenue

Telephone: (785) 368-8971
FAX: (785) 296-5857
www.ksrevenue.org

MEDICAL FORM INSTRUCTIONS

To the Driver:

- Make sure your full name and date of birth are legible.
- If your address has changed, please provide your full, current address (including city, state and ZIP code) to have it updated in our system.
- The medical form must be signed by the driver in order to be processed.
- Provide as many details as possible if you answer any question(s) as YES.
- If you are being treated by multiple physician(s), each physician must complete their own set of medical forms.

To the Physician(s):

- All items listed on Page 1 are considered medical conditions that could impair driving. If the driver answered YES to any of the questions on Page 1, make sure the diagnosis, prognosis and medication(s) are provided for the condition(s). The entire section IV. Physician's Certification must also be completed regarding any condition that you provided information for.
- You are responsible for providing information on condition(s) that you are treating. Therefore, different sections cannot be partially completed by different physicians.
- The restrictions listed are the only restrictions available to place on a driver's license.
- Restriction(s) cannot be removed by leaving the boxes unchecked. If you believe a restriction should be removed from a driver's license, please state on the form which restriction(s) can be removed at this time.
- If the questions "Driver is reliable in taking currently prescribed medications?" and "Driver's medical condition is controlled?" are answered YES, the diagnosis, prognosis and medication(s) must be provided on the form in order to process.
- If you were previously treating the driver for a medical condition that is now resolved, please state the following on the form:

  "The previous diagnosis of _____ is no longer valid. This driver is safe and controlled without medication."
- The medical form may be completed by an RN, APRN or PA but MUST be signed by the supervising physician (MD or DO) in order to process.

PLEASE RETURN COMPLETED MEDICAL FORMS TO:

PH: (785) 368-8971
FAX: (785) 296-5857

STATE OF KANSAS DIRECTOR OF VEHICLES
MEDICAL/VISION UNIT
915 HARRISON STREET
PO BOX 2188
TOPEKA KS 66601-2188

KANSAS DIVISION OF VEHICLES MEDICAL FORM

SECTION I: GENERAL DRIVER INFORMATION

Driver must complete Sections I and II.

Name: _____ Date of Birth:_____

Address:_____

Phone Number:_____ Driver's License Number:_____

Are you enrolled in Driver's Education? YES ☐ NO ☐

Instructor's Name:_____ Instructor's Phone #:_____

Permission is granted for release of all medical information concerning me to the Kansas Division of Vehicles and to all medical professionals who complete any part of this form.

Dr. _____

Signature of Driver: Date:

SECTION II: DRIVER MEDICAL HISTORY

If the answer to any of the following questions is "YES", please give sufficient details in the remarks area at the end of this section.

Are you currently being treated for any of the following conditions?

		Check One:	
1	Motor Vehicle Accident	YES☐	NO ☐
2	Driver's License Revocation / Suspension / Cancellation	YES☐	NO ☐
3	Blackout Spells / Dizzy Spells / Epilepsy / Seizures / Loss or Alteration of Consciousness in the waking state.	YES☐	NO ☐
	Date of last episode:_____		
	History of episode(s) (if YES, list dates): _____	YES☐	NO☐
4	Other Neurological Impairments	YES☐	NO ☐
5	Head Trauma / Brain Surgery	YES☐	NO ☐
6	Nervousness	YES☐	NO ☐
7	Depression / Confusion / Other Psychiatric Disorders	YES☐	NO ☐
8	Memory Impairment	YES☐	NO ☐
9	Alcoholism	YES☐	NO ☐
10	Visual Impairment / Eye Disease	YES☐	NO ☐
11	Drug Abuse	YES☐	NO ☐
12	Hearing Impairment	YES☐	NO ☐
13	Amputations / Missing Extremities / Prosthesis	YES☐	NO ☐
14	Other Orthopedic Impairments	YES☐	NO ☐
15	High Blood Pressure	YES☐	NO ☐
16	Heart Disease / Cardiovascular Impairments	YES☐	NO ☐
17	Diabetes	YES☐	NO ☐
18	Other Diseases / Ailments/Complications: list below	YES☐	NO ☐

Remarks: (Attach additional sheet if necessary) _____

SECTION III: PHYSICIAN'S REPORT

TO THE PHYSICIAN: Please complete the sections of this report applicable to this patient's diagnosis and add comments related to any questions marked "YES" by the patient in Section II. The physician assumes no liability. See Kansas Statute Section 8-247 (d) (6).

A. PHYSICAL EXAMINATION

1. Other Physical Impairment(s) e.g. Diseases / Ailments / Complications

Description: _____

_____

Diagnosis: _____

_____

Prognosis: _____

_____

Medication: _____

_____

B. PSYCHOLOGICAL EVALUATION

Is there any evidence of any Psychological Dysfunction? E.G. Excessive Tension / Anxiety / Depression Hostility / Behavior Disorders / Paranoia / Suicidal Tendencies / Impairment of Judgment / Developmental or Delayed Disability / Hallucinations / Delusions

Check One: YES ☐ NO ☐

If "YES", please provide:

Diagnosis: _____

_____

Prognosis: _____

_____

Treatment: _____

_____

Medications: _____

_____

ALCOHOL/DRUG DEPENDENCE?

Check One: YES ☐ NO ☐

If "YES", please provide:

Diagnosis: _____

_____

Prognosis: _____

_____

Treatment: _____

_____

Medications: _____

_____

SECTION III: NEUROLOGICAL EVALUATION

Is there any evidence of a Seizure / Syncope Event / Blackout / Dizzy Spell Disorder? If "YES", please provide: **Check One:**

In what state of consciousness did the episode occur? YES ☐ NO ☐

1. Type of Seizure / Syncope Event / Blackout / Dizzy Spell Disorder: WAKING ☐ SLEEPING ☐

_____

Date of most recent Seizure / Syncope Event / Blackout / Dizzy Spell / Loss or Alteration of Consciousness episode:

If a recent seizure is indicated, should the driver's medical condition be monitored for a period of six months? YES ☐ NO ☐

Current Medication(s):_____

Episode History (if YES, list all episode dates):_____ YES ☐ NO ☐

2. **Other** Neurological Impairment(s)::

Diagnosis: _____ Prognosis:_____

Progressive?_____

Date of most recent Loss or Alteration of Consciousness: _____

Current Medication(s):_____

Episode History (if YES, list all episode dates):_____ YES ☐ NO ☐

SECTION IV: PHYSICIAN'S CERTIFICATION

Recommendations / Restrictions to be placed on the License if issued: **(Limit 6)**

☐ Corrective Lenses ☐ Within City Limits ☐ Outside Mirror

☐ Daylight Hours Only ☐ Licensed Driver In Front Seat ☐ Automatic Transmission

☐ No Interstate / Freeway Driving ☐ Mechanical Aid ☐ (___)Miles From Home

☐ Outside Business Area ☐ Prosthetic Aid (5-30 in 5 mile increments)

Check One:

Driver must take and pass a drive test at a Kansas Exam Station. YES ☐ NO ☐

Annual Medical Report required. YES ☐ NO ☐

Driver is reliable in taking currently prescribed medications? YES ☐ NA ☐ NO ☐

Driver's medical condition is controlled? YES ☐ NA ☐ NO ☐

Driver's vision should be evaluated. YES ☐ NO ☐

Is this a new patient? YES ☐ NO ☐

(If YES, indicate whether or not you are familiar with his/her medical history) _____

In my professional opinion, I believe this person can safely operate a motor vehicle at this time in regards to their medical state. (Driver must be considered a safe candidate in order to request a drive test.) **Check One:** YES ☐ NO ☐

(Within the last 90 days)

Name of Physician:_____ **Exam Date:**_____

Physician License#:_____ Specialty:_____

Physician Address:_____ Phone#:_____

Other comments / recommendations to be considered regarding this driver's medical condition as it relates to his / her driving privileges:

_____

_____

Supervising Physician Signature: _____Date:_____