

CERTIFICATE OF EXAMINATION
For Permanent Conditions Only

FOR THE REPORTING PHYSICIAN:

Please check this box if the condition does not affect the patient's ability to drive a motor vehicle. If checked, it is not necessary to complete the Functional Ability Profile below.

1. This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition that could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office at (207) 624-9000, ext. 52124 Fax: (207) 624-9319.
2. A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A, M.R.S.A., Section 1258 (6).

FUNCTIONAL ABILITY PROFILE

This form cannot be completed without reference to the Functional Ability Profiles Booklet.

DIAGNOSIS

(Please print or type)

PROFILE LEVEL

*This section must be completed.
Check only one box per diagnosis.*

If COPD Profile level B or C, provide O2 SATS

	1.	2.	A.	B.	3.	C.	D.	4.
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of last examination (must be within the past year): _____

How long has the applicant been your patient? _____

No Medications

Current prescribed medication(s) and side effects experienced at present: _____

Reliability in taking medications: _____

Date of last seizure or loss of consciousness: _____

PHYSICIAN'S COMMENTS (Important – please describe physical and/or cognitive deficits.)

