REGISTRY OF MOTOR VEHICLES

# Medical Evaluation Form

Medical Affairs ● P.O. Box 55889, Boston, MA 02205-5889
Fax: 857-368-0018

I hereby authorize the physician completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Registry of Motor Vehicles.

Applicant's Signature: _____ Date: _____

**This form must be fully completed by a physician: a medical doctor who is licensed to practice in the Commonwealth of Massachusetts.**

## A. Patient Information

| Last Name | First Name | Middle Name | Suffix |
|---|---|---|---|
| | | | |

| Driver's License # | Date of Birth (MM/DD/YYYY) | |
|---|---|---|
| | / / | |

Reported Condition

_____

The Registry of Motor Vehicles has received information that the patient named above may have a condition which could affect the patient's ability to operate a motor vehicle. Please complete the following:

1. Please describe the patient's medical condition: _____

_____

_____

A. Does the patient have a respiratory disease/disorder? ..... ☐ Yes ☐ No

If so, indicate the patient's $O^2$ saturation rate at rest or with minimal exertion (with supplemental $O^2$, if used)

_____

_____

Other comments: _____

_____

B. Does the patient have a cardiovascular condition? ..... ☐ Yes ☐ No

If so, 1) Does the patient have an implanted cardiac defibrillator? ..... ☐ Yes ☐ No

2) Specify the American Heart Association ("AHA") functional class which most appropriately describes the patient's condition (see guidelines on reverse side) and symptoms

_____

_____

_____

2. Please describe the extent, frequency, and control of the symptoms of the patient's condition or disability which may affect the patient's ability to operate a motor vehicle:

_____

_____

3. Is the patient's medical condition or disability likely to interfere with the patient's mental or physical ability to operate a motor vehicle safely? ..... ☐ Yes ☐ No

If yes, describe: _____

_____

Patient Name: _____ Last 4 Social: _____

4. If condition involves seizure or any type of altered or loss of consciousness, please state type and date of last episode(s).

_____

_____

5. Is patient on any medication(s)? ..... ☐ Yes ☐ No

If yes, list medication(s) with dosage(s): _____

_____

_____

Are these medications, separately or in combination, likely to interfere with the patient's ability to operate a motor vehicle safely? ..... ☐ Yes ☐ No

6. **Please check one of the following categories**:

I hereby certify that in my professional opinion and to a reasonable degree of medical certainty, one of the following:

☐ The patient named above is medically qualified to operate a motor vehicle safely.

☐ The patient named above is NOT medically qualified to operate a motor vehicle safely.

☐ The patient may require adaptive equipment and/or an assessment for appropriate license restrictions via a competency road examination.

☐ I am unable to determine driving ability and recommend the patient undergo a competency road examination.

7. Please check one:

I have read the attached police report and am aware of the reported incident involving my patient. ..... ☐ Yes ☐ No ☐ N/A

Additional comments: _____

_____

## B. Physician Certification

| Physician's Name | Massachusetts Board of Registration # |
|---|---|
| | |

Address

Street City State Zip Code

**I hereby certify, under the pains and penalties of perjury, that the information I have provided herein is true, accurate and complete.**

Certifying Physician's Signature: _____ Date: _____

Classification Guidelines:

**AMERICAN ASSOCIATION FUNCTIONAL CLASSIFICATION SYSTEM**

| | |
|---|---|
| CLASS I | Patients with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause fatigue, palpitation, dyspnea, or anginal pain. |
| CLASS II | Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity result in fatigue, palpitation, dyspnea, or anginal pain. |
| CLASS III | Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain. |
| CLASS IV | Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased |