

PHYSICIAN'S OPINION STATEMENT - DRIVER FITNESS

On _____ I completed a physical examination of _____ date of birth _____ to determine his or her mental and physical fitness to operate a motor vehicle.

My findings are as follows:

General Health

1. Is there any nervous, organic, or functional disease which has advanced, or is likely to advance during the next 12 months, to a degree that will interfere with safe driving? Yes No
2. Has the applicant ever been treated or received medication for any nervous, neurological, mental or emotional disorders? _____ Yes No
3. Has the applicant ever been treated for epilepsy? Yes No

Mental Condition

4. Has a loss of alertness or mental activity adversely affected the applicant's ability to handle emergencies frequently encountered in driving? Yes No

Physical Condition

5. Has the applicant lost any extremities or limbs? _____ Yes No
 - a. Is there any partial or total loss of use of any extremity or limb that impairs safe driving ability? Yes No
 - b. Is there any other bodily defect or limitation that is likely to hinder safe driving? Yes No
 - c. Does the car have special controls? Details: _____ Yes No

Hearing

6. Any hearing loss which could interfere with safe driving? Yes No

Vision

7. Does the applicant have cataracts which have not been repaired? Yes No
8. Is peripheral (side) vision restricted? Yes No
9. Has the applicant lost the use of either eye? Yes No
10. Is there any opacity of the crystalline lenses of either or both eyes? Yes No
11. Visual Acuity With or Without Corrective Lenses
Both Eyes if same: 20/_____ Left Eye: 20/_____ Right Eye: 20/ _____
12. Date of last eye examination. _____
13. Do the above visual acuity ratings suggest an inability to safely operate a motor vehicle? Yes No

Summary

14. Please explain any "Yes" answers above: _____

15. Circle if applicable, and indicate date of last treatment (Convulsions, Loss of Equilibrium, Alcohol/Drug Abuse, Mental/Emotional Illness, Fainting Spells): _____
16. Are there any restrictions on your drivers' license other than glasses/contact lenses? Yes No
If yes, please give details: _____
17. Are there any conditions, not mentioned above, that could affect the applicant's ability to drive? Yes No
If yes, please give details: _____

Signature of Examining Physician

Signature of Applicant

Print Physician's Name: _____

Policy Number: _____

HUDSON INSURANCE GROUP

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