PLEASE RETURN COMPLETED MEDICAL FORMS TO:

STATE OF KANSAS DIRECTOR OF VEHICLES
MEDICAL/VISION UNIT
300 SW 29th STREET
PO BOX 2188
TOPEKA KS 66611

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

KANSAS DIVISION OF VEHICLES MEDICAL FORM

GENERAL INFORMATION & HISTORY – TO BE FILLED OUT BY THE PATIENT

NAME: _____ DRIVER LICENSE #: _____DOB:_____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE #:_____

Currently enrolled in Driver's Education? YES / NO If yes, instructor name & phone number: _____

RELEASE OF INFORMATION

Permission is granted for release of all medical information concerning me to the Kansas Division of Vehicles by all medical professionals filling out this form.

_____ _____
SIGNATURE OF PATIENT DATE

To the Medical and/or Psychological Professionals: Please complete the sections of this report applicable to this patient's conditions. You assume no responsibility in making this report other than that of truthfully representing the facts as they appear in your professional judgment. **The information on this form must be from an examination within the last 90 days.**

Instructions:

1. Please answer each question and fill out the entire form carefully and legibly.
2. Indicate yes or no whether from a medical and/or psychological standpoint only, this patient is capable of safely operating a motor vehicle.
3. Please note that if the patient has had a recent loss or alteration of consciousness, the exam date must be a full six months after the date of the last occurrence.
4. Specify any driving restrictions that are appropriate based on the patient's disease or medical and/or psychological condition.
5. If the patient should be seen by a specialist, a form must be taken to the specialist for completion. If the patient requires multiple exams, they may make copies of this form or contact the Medical/Vision Unit for additional copies. All treating physicians must complete a set of forms.

If you have questions, please call 785-368-8971.

SECTION I: PHYSICIAN'S REPORT

1. In your opinion, does this patient have a medical condition that could affect the patient's ability to safely operate a motor vehicle?
   ☐ Yes ☐ No ☐ Uncertain If yes or uncertain please explain:

   _____

   _____

2. Has the patient had any loss/lapse of consciousness, seizure activity, fainting or syncopal event in a waking state? ☐ Yes ☐ No

   If yes please indicate the date of the last occurrence (MM/DD/YYYY)_____

   In your opinion, is a six month revocation required for the most recent occurrence? ☐ Yes ☐ No

   Has the patient had any other occurrences within the last 3 years? ☐ Yes ☐ No

3. Should this patient be referred to a specialist (such as a neurologist or psychologist) to determine their ability to safely operate a motor vehicle?
   ☐ Yes ☐ No If yes, what type_____

4. Physician's Comments:

5. Indicate below which restrictions may apply to the patient's license if issued or continued: Maximum 6 restrictions.

☐ Corrective Lenses	☐ Daylight Hours Only	☐ No Interstate Driving	☐ Outside Business Area
☐ Within City Limits	☐ Licensed Driver in Front Seat	☐ Automatic Transmission	☐ Outside Mirror
☐ Mechanical Aid	☐ Prosthetic Aid	☐ _____Miles From Home (5-30 in 5 mile increments)	

6.	Should an actual test of the patient's driving ability be administered?	☐ Yes	☐ No
7.	Should an annual medical report be required to be filed with the Division of Vehicles?	☐ Yes	☐ No
8.	**This patient is capable of safely operating a motor vehicle. (Driver must be considered a safe candidate in order to request a drive test.)**	☐ Yes	☐ No
9.	Does this patient require a vision exam?	☐ Yes	☐ No

Name of Medical Professional & License # (Please print)

Date of Examination

Medical Professional's Specialty

Signature of Medical Professional

Address

Date Signed

Phone