

****THIS EVALUATION MUST BE COMPLETED IN FULL OR IT WILL BE RETURNED****

ANY MEDICAL CHARGES INCURRED ARE THE RESPONSIBILITY OF THE PATIENT

INDICATE REASON FOR THE EVALUATION

Complete Sections A, B, D & E if you are selecting one of the four reasons below. See front and back of form.

- | | |
|--|---|
| <input type="checkbox"/> Applying for a Vermont License/Permit | <input type="checkbox"/> Department Request |
| <input type="checkbox"/> School Bus Endorsement (Type II) | <input type="checkbox"/> New/Update Medical Condition |

Complete ALL Sections if requesting a **DISABLED PLACARD OR PLATES**. See front and back of form.

- | |
|--|
| <input type="checkbox"/> Disabled Parking Placard (must be accompanied by a Disabled Parking Placard Application ~ TA-VD-120) |
| <input type="checkbox"/> Disabled Parking Plate (must be accompanied by a Registration, Tax and Title Application ~ TA-VD-119) |

** PARKING PLACARD APPLICANTS: THE INFORMATION IN THIS MEDICAL MAY BE CONSIDERED IN DETERMINING YOUR LICENSE STATUS**

SECTION A - TO BE COMPLETED BY APPLICANT

Patient's Name:	
Street / Road / Box Number	
Patient's Mailing Address:	City / State / Zip Code
Physical Address – If Different From Mailing Address	
Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Check If The Above Is A Change To Your: <input type="checkbox"/> MAILING ADDRESS <input type="checkbox"/> PHYSICAL ADDRESS
Date Of Birth	Social Security Number
VT Driver License/Id Number	
If This Is A Name Change, List Former Name:	
I certify that the information contained above is true, complete and correct to the best of my knowledge. Statements and warrants herein are certified under penalty of 23 V.S.A. §202 & §203.	
➤ APPLICANT'S SIGNATURE:	

SECTIONS B, C, D & E – TO BE COMPLETED BY MEDICAL EXAMINER

SECTION B

- Patient has been under my care for _____ years.
- Check any of the following conditions that apply:

<input type="checkbox"/> SEIZURES	<input type="checkbox"/> CANCER	<input type="checkbox"/> SPINAL INJURY	<input type="checkbox"/> HYPERTENSION
<input type="checkbox"/> DIABETES	<input type="checkbox"/> COPD	<input type="checkbox"/> ARTHRITIS/DEGENERATIVE JOINT DISEASE	
<input type="checkbox"/> AMPUTATION: ARM: <input type="checkbox"/> Left <input type="checkbox"/> Right LEG: <input type="checkbox"/> Left <input type="checkbox"/> Right Describe cause and extent (example: at elbow, below knee) of amputation: _____ _____		<input type="checkbox"/> PERMANENT DISABILITY/ CONDITION: Specify: _____ _____ _____	
		<input type="checkbox"/> PSYCHIATRIC DISORDER: Specify: _____ _____ _____	
- Blood pressure reading is required for **all school bus driver medicals**.
 For other licensed drivers, only indicate if a medical condition exists.

Systolic:	Diastolic:

RATER #:	DEPARTMENT USE ONLY SECTION		MEDICAL DATE: MM/DD/YYYY
	TRANSACTION TYPE:	TYPE:	
	<input type="checkbox"/> ADD	<input type="checkbox"/> A – SCHOOL BUS	
	<input type="checkbox"/> UPDATE	<input type="checkbox"/> B – NOT STABLE <input type="checkbox"/> D – STABLE	

CONTINUED ~ SECTIONS C, D & E – TO BE COMPLETED BY MEDICAL EXAMINER

SECTION C – PARKING PLACARD/PLATES

I hereby attest to the fact that at the time of the examination the applicant:

- Check-mark the applicable disability. Has an irreversible visual impairment, or
One must be check-marked. Has an irreversible ambulatory disability within the meaning of 23 VSA §304a.

SECTION D – MEDICAL EXAMINER’S OPINION

1. I have examined the patient and in my opinion: (Check-mark one of the statements below.)

- The patient **IS NOT** medically fit to drive any motor vehicle on the highway.
 There are no reasonable **medical** grounds to limit driving privileges.
 The patient is medically fit to drive a motor vehicle, however, they should:
 Submit progress reports to the Department of Motor Vehicles every: _____ Months _____ Years
 Be further evaluated for driving ability.

Comments: _____

2. **Patient’s condition is totally stable:** Yes No

SECTION E – MEDICAL EXAMINER’S CERTIFICATE

THIS FORM MUST BE COMPLETED BY A LICENSED PHYSICIAN, EXCEPT AS STATED BELOW.

- If the medical is for School Bus requirements, it must be signed by a Licensed Physician, Physician Assistant or a Nurse Practitioner.
- If the applicant has or is applying for a Vermont license, without a School Bus endorsement, the medical must be signed by a Licensed Physician. **Exception:** A Physician Assistant may sign the medical, if co-signed by a Licensed Physician.
- If the applicant is applying for Disabled Parking Placard or Disabled Parking Plates, the medical must be signed by a Licensed Physician, Certified Physician Assistant or Licensed Advanced Practice Registered Nurse.

I certify that the information contained herein is true, complete and correct to the best of my knowledge. Statements and warrants made herein are certified under penalty of 23 V.S.A. §202 & §203.

DATE OF EXAM (MM/DD/YYYY)

DATE OF EXAM MUST BE ENTERED AT LEFT AND BE WITHIN THE LAST 6 MONTHS TO BE ACCEPTABLE.

MEDICAL EXAMINER’S SIGNATURE

DATE

MEDICAL EXAMINER’S NAME (PRINT CLEARLY)

PHONE NUMBER

STREET/ROAD/BOX NUMBER

CITY/STATE/ZIP CODE

MEDICAL EXAMINER’S MAILING ADDRESS

CLASSIFICATION OR SPECIALTY

TITLE

LICENSE STATE

LICENSE #