Materials Used By Michigan

MC-27 (5-98)
MICHIGAN STATE POLICE
MOTOR CARRIER DIVISION

APPLICATION
MEDICAL WAIVER - PHYSICAL DISABILITY
Requirements

(Application on Reverse Side)

This application is to apply for a waiver of the Michigan Motor Carder Safety Act under the provision of MCLA 480.12k, for a driver not physically qualified to drive under MCLA 480.121. An incomplete application may result in processing delays. Providing false or misleading information could result in the denial of a waiver.

Submit the following required items with the application:

1. Copy of the applicant's official driving record from the Secretary of State, listing accidents, driving arrests, license suspensions, revocations or withdrawals, and convictions wlthin'the last five years.

2. Two reports of medical examinations made pursuant to 49 CFR 391.43, which include the medical examiner's opinion concerning the individual applicant's ability to safely operate a vehicle of the type the applicant intends to drive.

   a. One medical examination shall be conducted by a medical examiner' selected and compensated by the motor carrier.

   b. The other examination shall be conducted by a different medical examiner.

3. A copy of the driver's application for employment

4. Copies of all medical waivers Issued to the applicant by local; state, or federal agencies.

The applicant may also be required to successfully complete a driving skill performance evaluation administered by the Appeal Board.

It is the responsibility of the employing motor carrier to evaluate the driver with a road test using the trailer type(s) the motor carrier intends to operate, or In lieu of, 'accept a certificate of a trailer road test from another carrier If the trailer type(s) is similar. Also, It is the responsibility of the employing motor carrier to evaluate the driver for those non-driving, safety-related, job tasks associated with the type of trailer(s) used, as well as any other non-driving safety-related or job-related tasks unique to the operations of the employing motor carrier.

The "Grandfather Rights" waiver and the "Physical Disability" waiver do not exempt drivers from the drug and alcohol testing requirements. All Grandfather Rights waivers will expire on December 31, 2032.

Return completed form and other required items to:

Motor Carrier Safety Appeal Board
Michigan State Police
Motor Carrier Division
P.O. Box 30632
Lansing, Michigan 48909-8132

If you have any questions call: (517) 336-6416

OVER

AUTHORITY:	1963 PA 181
COMPLIANCE:	Voluntary, but misdemeanor penalty if driver operates without medical certification or waiver.

Application for Medical Waiver - Physical Disability (Joint Application - Company and Driver)

Employer's Name (Company)	PhoneNo. ( )
Mailing Address	
Driver's Name	Phone No. ( )
Home Address	
Date of Birth / Driver's License No.	
Disqualifying Medical Condition	Date of Medical Condition Onset
Make of Commercial Vehicle Driven / Vehicle Model	Vehicle Year
Type of Transmission	Vehicle Type ☐ Straight Type ☐ Tractor-Trailer ☐ Double
Maximum Gross Weight	Brake System ☐ Air ☐ Hydraulic ☐ Other
Steering ☐ Manual ☐ Power	Type of Trailer(s)
Describe Necessary Vehicle Modifications (Attach Photo, if used)	
Area of Operation	Type of Roads ☐ X-Way ☐ State Highway ☐ County Road ☐ City Street
Maximum Daily Mileage	On-Duty Driving ☐ Daylight ☐ Darkness
Commodities/Cargo to be Transported	
Driver's Duties in Loading/Unloading Cargo	
Driver's Duties in Securement of Cargo	
Driver's Duties for Emergency Repair of Vehicle	
Years of Experience Driving Vehicle Described Above / Years of Experience Operating Commercial Vehicles / Employment Date With Above Named Employer	

If this waiver is granted, we agree to the following conditions:

1. The waiver authorizes the applicant to drive only when operating in intrastate commerce.
2. The waiver is valid only while the applicant is transporting any commodity other than those materials regulated by the United states Department of Transportation in intrastate commerce.
3. If application is made under MCLA 480.12k, this waiver is valid only while the applicant is employed by the motor carrier listed above.
4. We will promptly file such reports with the Appeal Board as the Board may require.

We hereby certify the following:

1. That the applicant is qualified to drive a motor vehicle under provisions of 49 CFR Part 391.
2. That the above information is true.

Company Offical (Printed Name,	Title
Signature X	Date
Driver (Printed Name)	
Signature X	Date

MC-27 (5-98)

MACHINE COPY AS NEEDED

Motor Carrier Safety Appeal Board
4000 Collins Road
P.O. Box 30632
Lansing, MI 48909-8132
ATTN: Diane (517/336-6416)

PHYSICIAN'S STATEMENT OF EXAMINATION

INSTRUCTIONS FOR DRIVER/APPLICANT:

The Department of State has received information that you may be afflicted. with a physical or mental condition that may affect your ability to safely operate a motor vehicle. Please have your physician complete this form. **The completed form must be** returned **to the above address; It cannot be processed at a local licensing bureau.**

PLEASE NOTE: The Department of State may withhold licensing pending receipt and evaluation of this form. Unsigned or incomplete forms will be returned for completion. **Highlighted areas must be completed for statement to be processed.**

RELEASE OF INFORMATION

Name Driver's, License No.

I, (Please Print or type) _____
hereby authorize and request that information regarding my physical and psycholoaical condition be released to the Michigan Department of State.

Signature DATED

Street DATE OF BIRTH

City State Zip TELEPHONE NO.

INSTRUCTIONS FOR PHYSICIAN:

The Department of State asks your assistance in determining the physical and/or mental condition of your patient. Your professional opinion, the answers to these questions and any other pertinent information will help the Department assess this individual's ability to safely operate a motor vehicle. Information may be mailed directly to the Department at the address shown in the instructions to Driver above.

Please type or print your answers and attach EG or EKG evaluations if applicable.
You need only fill out the section(s) indicated pertinent to this person.

( ) Neurological or Neuromuscular Diseases page 2
( ) Other Medical Disorders page 3 & 4
( ) Drugs and Alcohol page 4
Psychological Evaluation page 5
' Comments page 6

Certification by physician's signature is required on page 6.

FOR DEPARTMENT USE ONLY

( ) Favorable ( ) set up _____
( ) Restriction _____
( ) Must Pass _____ test.
( ) Unfavorable _____ ( ) Questionable _____
( ) Refer for reexamination _____
( ) Refer to Health Consultant _____
( ) Need additional information: _____
( ) Medical _____ ( ) Vision _____
REVIEWED BY _____ Date _____

NEUROLOGICAL AND NEUROMUSCULAR DISEASE

DISEASE CAUSING LOSS OR IMPAIRMENT OF CONSCIOUSNESS OR CONFUSION

( ) Epilepsy -Type: _____
( ) Narcolepsy
( ) Alcoholism -Also complete Alcohol and Drug Section on page 4
( ) Cerebral Vascular Disease-Also complete Atherosclerosis/Heart Disease: Section page 3
( ) Cerebral Insufficiency-Also complete Atherosclerosis/Heart Disease: Section page 3
( ) Vasovagal Syncope _____
( ) Other (Open & closed head injuries, craniotomies, etc.) _____

A. Age at onset of illness:
B. Has patient reported seizure or attack within last 6 months? No ____ Yes____ 12 months? No - Y e s _ _
(i) Date of last episode: _____
(ii) Frequency of seizures or attacks: _____
C. Current medication and dosage: _____

D. Is there a reasonable medical certainty that the last seizure or attack resulted from a medically supervised change in medication or dosage? No _____ Yes _____
If yes, please explain: _____

E. Has patient had any adverse or other reaction to treatment or medication) If yes, please explain: _____

II. **OTHER LIMITING OR PROGRESSIVE NEUROLOGICAL OR NEUROMUSCULAR DISEASES, (CEREBRAL PALSY, PARAPLEGIA, MUSCULAR DYSTROPHY, PARKINSONISM, MULTIPLE SCLEROSIS, ETC.)**

A. Specific diagnosis: _____
B. Age at onset of illness: _____
C. Please describe patients neurological or neuromuscular condition. Is the condition likely to change in the future?

D. Current medication and dosage: _____

E. Is the patient's condition or disease adequately controlled with medication?
No____ Yes____

OTHER MEDICAL DISORDERS

I. DIABETES AND OTHER METABOLIC DISORDERS

A. Type #I _____ Type #2 _____ Age at onset _____
Insulin injections: No _____ Yes _____ Strength _____ Frequency _____
Does Patient follow diet instructions? No _____ Yes _____ Comments _____

Is the patient responsible in the management of the disease? No _____ Yes _____
Comments _____

B. Reaction episodes those causing loss of or impairment of level of consciousness:
Hypoglycemic No _____ Yes _____ Frequency _____
Hyperglycemic No _____ Yes _____ Frequency _____
Renal Disease No _____ Yes _____ BUN _____
Creatinine _____
Was the episode unusual in nature for this driver? No _____ Yes _____
Please explain _____

C. Date of last episode _____
Symptoms:
Impairment of level of consciousness No _____ Yes _____
Loss of Motor Skills No _____ Yes _____
Loss of Judgment No _____ Yes _____
Required Assistance from others No _____ Yes _____
Difficulty Recalling the episode No _____ Yes _____
Please describe any yes responses _____

Has patient's condition stabilized? No _____ Yes _____

D. Is there reasonable medical certainty that the last reaction episode resulted from a medically supervised change in medication or dosage? No _____ Yes _____
Please explain _____

E. Date of last blood glucose test: _____ Blood Glucose level: _____ Frequency of tests: _____

F. Vision Problems No _____ Yes _____ Please describe _____

II ATHEROSCLEROSIS/HEART DISEASE

A. Diagnosis: _____

B. Peripheral vascular disease: No - Yes _____ Location of disease, i.e., arms, legs, etc. and extent of disability: _____

C. Cerebral vascular disease: No _____ Yes _____

D. Coronary vascular disease: No _____ Yes _____
Angina: No _____ Yes _____ Frequency _____ Date of Onset _____
During Driving No _____ Yes _____
Dyspnea: No _____ Yes _____
Syncope: No _____ Yes _____ Near Syncope or Confusion: No ___ Yes ___
Frequency _____
Arrhythmia: No _____ Yes _____ Frequency _____ Type _____
Infarction: No _____ Yes _____ Dates _____
Congestive Failure: No _____ Yes _____ Ever: No _____ Yes _____
Pacemaker: No _____ Yes _____
Hypertension: No _____ Yes _____ Blood Pressure: _____
Heart Rate: _____

OTHER MEDICAL DISORDERS (con't)

E. Medication and Dosage _____

F. Has patient had any adverse or other reaction to medication or treatment for condition?
If yes, please explain: _____

G. Has patient reached maximum recovery period? _____ If no, expected date: _____
Functional Classification: I II III IV
Therapeutic Classification: A B C D E

H. Is the above condition medically treatable? _____

I. Please describe how this condition may affect the patients ability to drive safely. _____

_____

III GENERAL MEDICAL CONDITONS (conditions not covered in other sections)

A. Diagnosis _____

B. Current medication and dosage: _____

C. Has the patient had any adverse or other reaction to treatment or medication? No _____ Yes __

DRUGS AND ALCOHOL

1. Does the patient have any clinical evidence or do you have personal knowledge of patient's addiction to habituation to drugs, alcohol or tranquilizers? No _____ Yes _____
Indicate drug and duration of addiction, etc.: _____

_____

2. Has patient been subject to residential treatment or hospitalization for this condition? No _____ Yes _____
Dates of treatment or hospitalization: _____

3. Is patient currently under therapy? No _____ Yes _____ Where? _____
Duration and frequency of therapy: _____

4. Is there evidence of physical complications from alcohol or drug abuse: No _____ Yes _____
Please explain: _____

_____

5. Has patient been advised to abstain from addicted substance? No _____ Yes _____

6. Has patient followed your recommendations for treatment and therapy? No _____ Yes _____

7. Has patient been prescribed antabuse? No _____ Yes _____

8. Is patients antabuse therapy monitored? No _____ Yes _____
By whom and frequency? _____

9. Has a period of abstinence or control been established? Please describe: _____

_____

10. What is your prognosis for this condition? _____

_____

_____

_____

_____

_____

PSYCHOLOGICAL EVALUATION

1. Diagnosis of psychiatric illness: _____

_____

Which of the following symptoms are present? (Please Check)

( ) Anxiety
( ) Depression
( ) Euphoria
( ) Poorly controlled anger
( ) Bizarre behavior
( ) Other _____
( ) Paranoid ideation
( ) Suicidal Impulses
( ) Homicidal impulses
( ) Insomnia
( ) Delusions
( ) Hallucinations
( ) Impairment of judgment
( ) Poor Memory
( ) Mental retardation
( ) Senility or Dementia

Pleae amplify on any of the above or other disorders. Include approximate duration Of illness severity of illness, treatment and prognosis: _____

_____

2. Current medication and dosage: _____

_____

3 Any adverse or other reactions to medication, treatment or therapy? Please explain: _____

_____

_____

a. Does medication make patient drowsy? No _____ Yes _____

b. Is patient capable of safely operating a motor vehicle while taking the above prescribed medication(s)?
No _____ Yes _____ Please explain: _____

_____

4. Has patient ever been hospitalized for the disorder? No _____ Yes _____ Please indicate when, where and for how long: _____

_____

_____

5. Frequency of therapy: _____

6. Do you believe this patient is capable of safely operating a motor vehicle? No _____ Yes _____
Please explain: _____

_____

7. Doss the patient follow your medical and psychiatric recommendations? No _____ Yes _____
Please explain: _____

_____

_____

_____

COMMENTS

1. How long has this patient been under your treatment? _____
   Frequency of visits _____
   Date of last visit: _____

2. Was patient referred to you by another doctor? No ____ Yes ____ If yes, please indicate name and address of referring doctor: _____

3. Have you referred the patient to another medical specialist for diagnosis or treatment?
   No _____ Yes _____ If yes, please indicate name and address of doctor to whom referred and results of consultation: _____

4. Has patient followed your medical recommendation? No ____ Yes ____
   a. Does patient keep appointments? No ____ Yes _____
   b. Does patient take medication as prescribed? No ____ Yes ____

5. Has the patient ever had occupational or physical therapy for the condition in question? No ____ Yes ____
   If yes, what date(s), where and for how long? _____

6. Do you recommend that the Department request a statement of your patient's:
   Psychological Condition? No __ Yes __
   Visual Acuity? No _____ Yes ____

7. Any adverse or other reactions to medication, treatment or therapy? Please explain: _____
   a. Does Medication make patient drowsy? No ____ Yes ____
   b. Is patient capable of safely operating a motor vehicle while taking the above medication(s)?
   No Please explain: _____

8. Do you recommend any driving restrictions? No ____ Yes ____ If yes, please specify: _____

9. Do you recommend the Department conduct an on-the-road driving performance evaluation for this driver at this time? No _____ Yes __
   Periodically? No _____ Yes ____ How often? _____

10. Should the Dept. require periodic medical evaluation to monitor changes which may affect driving?
    No - Yes ____ How often? _____

11. Please include any additional information you feel will help in assessing your patient's ability to operate a motor vehicle: _____

CERTIFICATION

I certify that the statements contained in this statement of examination are true to the best of my knowledge and belief.

DOCTOR'S SIGNATURE _____ DATED _____

Name (Print or Type) _____

Address _____

Professional License No. _____ Telephone No. ( ) _____

Type of practice or medical specialty _____

Authority granted under Act No. 300 of the Public Acts of 1949, as amended

MAIL TO:

Motor Carrier Division
Mich. Dept. of State Police

VISION SPECIALIST
STATEMENT OF EXAMINATION

INSTRUCTIONS FOR DRIVER/APPLICANT:

You must have this Statement completed by a vision specialist. This request is based on results of a vision screening at a local branch office, Or other information received by this Department which indicates that you may have a visual condition which may affect your ability to safely operate a motor vehicle. Please return the completed form to the following address.

Motor Carrier Division

Michigan State Police
MOTOR CARRIER DIVISION
P.O. Box 30632
Lansing, MI 48909-8132

PLEASE NOTE: The Department may withhold licensing until this form is received and evaluated.

RELEASE OF INFORMATION

I, (Please Print or Type) _____ hereby authorize and requested that information regarding my visual condition be released to the Michigan Department of State.

Driver License No.- _____

APPLICANT'S SIGNATURE _____ DATED _____

ADDRESS _____ DATE OF BIRTH _____

_____ DAYTIMETELEPHONE _____

INSTRUCTION FOR VISION SPECIALIST:

The Department of State asks your assistance in determining the visual condition of your patient. Your professional opinion, the answers to these questions and any other pertinent information will help the Department assess this individual's ability to safely operate a motor vehicle.
Confidential information may be mailed directly to the Department at the address shown in the instructions to the Driver, above

Please type or print your answers and if applicable, attach copies of abnormal fields.

Certification by vision special&s signature is required on page 3.

FOR DRIVER IMPROVEMENT USE ONLY

( ) Favorable ( )set up _____ ( ) 'Refer for reexamination

( )Restriction _____ ( ) Refer to Health Consultant

( ) Must Pass _____ test ( ) **Need additional information**

( ) **Unfavorable** ( ) **Medical** ( ) **Vision**

Reviewed By _____ Date _____

1. How long has this patient been under your care? _____

2. Date of most recent visual exam? _____

3. Visual acuity:		Without Lenses	With Present Lenses	Best Possible Correction
Right Eye	(OD)	20/	201	201
Left Eye	(OS)	20/	20/	20/
Both Eyes	(OU)	20/	20/	201

*** * * Drivers with vision of 201100 or less in one eye and the other eye as follows:**

. up to and including 20150. full driving privileges

. less than 20/50 not eligible for licensing

3a. Were new lenses prescribed? _____ If yes, date of delivery? _____

3b. Does the driver have any progressive diseases of the eye such as:

	yes	
. Cataracts	_____	_____
. Glaucoma	_____	_____
. Senile Macular Degeneration	_____	_____
. Retinitis Pigmentosa	_____	_____
. Any malignancy	_____	_____
. Other	_____	Describe _____

3c. Specify other reasons for visual impairment _____

~~* Vision with NO progressive abnormalities or disease of the eye:~~
~~- less than 20/40 to and including 20/50 - full driving privileges~~
~~- less than 20/50 to and including 20/70 - daylight driving only~~
~~- less than 20/70 - not eligible for licensing~~

~~* Vision WITH progressive abnormalities or diseases of the eye:~~
~~- less than 20/40 to and including 20/50 - full driving privileges~~
~~- less than 20/50 to and including 20/60 - daylight driving only~~
less than 20160 not eligible for licensing

4. Peripheral Vision

Horizontal Fields in degrees

Right Eye (OD) _____

Left Eye (OS) _____

Both Eyes (OU) _____ total * *

4a. Do you suspect visual field defect? Yes _____ No _____
IF SO, ATTACH COPY OF ABNORMAL FIELD

4b. Method used and test object size _____

Tangent screen _____ Perimeter _____

(6 millimeter target is used in Driver License Stations)

*** * 140° to and including 110 full driving privileges**
. less than 110° to and including 90*. Subject to additional conditions and requirements
. less than 90°. not eligible for licensing

5. Should the Department require a periodic vision evaluation to monitor changes' which may affect driving? _____

If yes, how often? _____

6. If you wish to make additional comments, please use the space below or additional sheets if necessary.

_____

_____

_____

_____

_____

_____

CERTIFICATION:
I certify that the Statements contained in this statement of examination are true to the best of my knowledge and belief.

DOCTOR'S SIGNATURE _____ DATED _____

Name (Print or Type) _____ **Optometrist or ophthalmologist**

Address _____

_____

Professional License No _____ Telephone No ( ) _____

Materials Used by Delaware

STATE OF DELAWARE DEPARTMENT OF PUBLIC SAFETY
DIVISION OF MOTOR VEHICLES
DRIVER IMPROVEMENT UNIT MEDICAL RECORDS SECTION
PO BOX698 - DOVER, DE 19903-0698

Name: _____ DOB License Number: _____

Address: _____

I hereby authorize Doctor _____ to perform any medical examination necessary for the purpose of determining my fitness to operate a motor vehicle. Also I understand that this authorization includes permission for the Director of Motor Vehicles and/or their designee to have this informatiin reviewed by a Medical Board of unidentified physicians for the purpose of giving him/her a medical opinion on my case for a guidance in determining my medical capabilities to operate a motor vehicle safely. The information contained in this report is confidential and will be used solely for the purpose of drivers license considerations.

_____

Date Signature of Applicant

PHYSICIAN'S FINDINGS

Legibility is a must

Mental level for reading (circle one) Inadequate * Marginal -Adequate Height: _____ Weight _____

(A) ORTHOPEDIC AND NEUROMUSCULAR: *(Please check as* appropriate)

Spastic, Amputations or Ankylosed Joints ☐ YES ☐ NO Joint Ataxia, Paralysis, or Weakness ☐ YES ☐ NO
Prosthetic Devices used for Driving ☐ YES ☐ NO Other Deformities or Abnormalities ☐ YES ☐ NO
If YES to any of the above. please describe: _____

(B) CARDIO-VASCULAR: *(P/ease check as* appropriate)

Strokes -Adams Syndrome ☐ YES ☐ NO Syncope ☐ ☐ NO Vertigos ☐ ☐ NO
Angina Pectoris ☐ YES ☐ NO Arteriosclerosis ☐ YES ☐ NO Arrhythmia ☐ YES ☐ NO
Cardiac Decompensation ☐ YES ☐ NO Dyspnea ☐ YES ☐ NO Blood Pressure _____
If YES to any oithe above, please describe: _____

(C) DIABETES: *(Please check* as *appropriate)*

Is he/she a known diabetic? ☐ YES ☐ NO Status of Control _____
Duration: _____ Diabetic Acidosis ☐ YES ☐ NO _____
If YES to any of the above, please describe: _____

(D) HEARING: Normal? ☐ YES ☐ NO If NO, please describe: _____

(E) DRUGS AND/OR ALCOHOL: *(Please* check.as appropriate)

Any objective evidence or personal knowledge of addiction, habituation, or alcoholism? ☐ YES ☐ NO
If YES, please explain: _____

 Patient Name: _____ DOB

(F) PSYCHOLOGICAL ASSESSMENT: (Please ***check*** as appropriate

Is there any evidence of emotional instability? ☐ YES ☐ NO Is further examination suggested? ☐ YES ☐ NO
Does he/she have or has he/she had any episodes of conditions listed below?

Mental Clouding	☐ YES ☐ NO	Blackouts	☐ YES ☐ NO	Dizziness	☐ YES ☐ NO
Unconsciousness	☐ YES ☐ NO	Convulsions	☐ YES ☐ NO		

If YES to any of the above, please explain nature and date of last episode: _____

Diagnosis: _____

(G) Does he/she have any other condition of diseases which would decrease ability to safely operate a motor vehicle? (P/ease ***check as appropriate)*** ☐ YES ☐ NO
If YES, please explain: _____

(H) What type(s) and quantities of drugs are being prescribed for the patient? _____

(I) Do any of the above medications affect driving ability? (Please check as appropriate) ☐ YESONO
If YES, please explain: _____

(J) From a medical standpoint, do you feel he/she is capable of operating a vehicle safety? ☐ YES ☐ NO
If NO, please explain: _____

If YES. the treating physiclan must attest to one of the two below listed statements, as may be applicable, for any person who Is subject to loss of consciousness due to disease of the central nervous system.

☐ I hereby certify that I am the treating physician duty. licensed to practice medicine and surgery in this State, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of "the central nervous system, and that such person's infirmity is under sufficient control to permit him/her to operate a **motor** vehicle with safety to person and property.

☐ I hereby certify that I am the treating physician, duty licensed to practice medicine and surgery in this State, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's disease no longer requires treatment and that such person can reasonably expect to suffer no further losses of consciousness on account of such disease.

(K) How long have you been treating this patient? _____ Date of last examination: _____

(L) Additional comments: _____

Physician's Name (Printed or typed) **Physician's Signature**

Address **Phone Number**
Date:

Please mail form to: MEDICAL RECORDS SECTION DRIVER IMPROVEMENT UNIT PO Box 698 Dover DE 19903-0698
The form may be transmitted by facsimile to: (302) 739-2602 ATTN: MEDICAL RECORDS SECTION

FORM: MV-346

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