

**SOUTH DAKOTA DEPARTMENT OF PUBLIC SAFETY  
DRIVER LICENSING PROGRAM**

**MEDICAL STATEMENT**

Name of Applicant \_\_\_\_\_

DL# \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State/Zip)

Birthdate \_\_\_\_\_

Permission is hereby granted for the release of the medical data below, and other medical history applicable in my case, to the South Dakota Department of Public Safety, Driver Licensing Program. I certify that I am currently under the care of a physician and I continue to take all medications prescribed.

I declare and affirm, under the penalties of perjury, that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. Any false statement or concealment of any material facts subjects any license issued to immediate cancellation.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY FORM (this portion must be completed by your physician):**

**\*\*Leave no blanks\*\***

Has the patient had episodes of altered states of consciousness (epileptic or narcoleptic episodes or **any other** convulsions, seizures, or blackouts)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, to your knowledge, is patient on therapeutic levels and compliant with taking prescribed medication? Yes \_\_\_\_\_ No \_\_\_\_\_  
To your knowledge, are the episodes under control? Yes \_\_\_\_\_ No \_\_\_\_\_

Indicate the number of months the patient has been episode free. \_\_\_\_\_

Does patient have any other physical, neurological, or mental illness which, in your professional opinion, would prevent him/her from safely operating a motor vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide a detailed explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you the applicant's primary healthcare provider? Yes \_\_\_\_\_ No \_\_\_\_\_

How long have you been advising applicant on their healthcare? \_\_\_\_\_

Please provide any additional comments/information that would assist in determining whether the patient can safely drive.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name (please print legibly) \_\_\_\_\_

Physician's Address (please print legibly) \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Return completed form to: Department of Public Safety, Driver Licensing Office, 118 W. Capitol Avenue, Pierre SD 57501 or fax to (605) 773-3018.