SOUTH DAKOTA
DEPARTMENT OF PUBLIC SAFETY
prevention ~ protection ~ enforcement

CONFIDENTIAL

DRIVER MEDICAL EVALUATION

Instructions: *Print clearly and legibly. If any section of this form is incomplete, it may be returned to the medical specialist for completion.*

APPLICANT INFORMATION

FULL NAME (Printed)	DRIVER LICENSE NUMBER
MAILING ADDRESS (including city, state, zip)	DATE OF BIRTH

APPLICANT: *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 this 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 my license to immediate cancellation.

Applicant's Signature _____ *Date* _____

DOCTOR: ***Your experience and knowledge of the patient's condition, results of medical examinations, and treatment plans will be of great value in assisting Driver Licensing to make a determination for proper licensing. Please answer all questions that are applicable to your patient's condition. South Dakota Statutes 32-12-5.1, 32-12-32, 32-12-35 and 32-12-49, give the department the authority to cancel a person's driver license and/or deny a driver license to a person who has a medical condition that in the opinion of their treating physician results in the patient's inability to safely operate a motor vehicle. The information contained in the report is confidential and will be used to determine eligibility/restrictions for licensing.***

THIS FORM MAY ONLY BE COMPLETED & SIGNED BY A QUALIFIED MEDICAL PROFESSIONAL
Information must be from exam within last 6 mos.

EXAMINATION INFORMATION *(check all that apply and please do not abbreviate)*
(Please include approximate month-day and year of last episode)

_____EPILEPSY, SEIZURE DISORDER OR SEIZURES -- **DATE OF LAST EPISODE:** _____
_____ LOSS OF MUSCULAR CONTROL -- **DATE OF LAST EPISODE:** _____
_____LOSS OF CONSCIOUSNESS -- **DATE OF LAST EPISODE:** _____
_____LOSS OR IMPAIRMENT OF A LIMB -- **DATE OF LOSS OR IMPAIRMENT:** _____
_____ OTHER _____

HOW LONG HAS THE ABOVE APPLICANT BEEN YOUR PATIENT?

DOCTOR MUST RESPOND TO APPLICABLE QUESTIONS BELOW OR FORM WILL BE RETURNED.

1._____this patient's condition is being medically controlled
2._____this patient's condition does not affect his/her ability to safely operate any type of motor vehicle
3._____this patient's condition renders him/her incapable of safely operating any type of motor vehicle
4._____this patient's condition does not affect his/her ability to safely operate a private motor vehicle; however, he/she should not operate a heavy vehicle (Class A or B type vehicle).
5._____the following restrictions should be placed on the applicant' driver license: _____ NONE

_____ AUTOMATIC TRANSMISSION
_____ NO DRIVING OUTSIDE OF TOWN
_____ SPECIAL EQUIPPED VEHICLE
_____ OTHER RESTRICTIONS: _____
_____ NO NIGHT DRIVING
_____ MUST STAY WITHIN A 50-MILE RADIUS OF RESIDENCE

6._____this patient should be required to submit a "Driver Medical Statement" annually to the Department to determine if patient meets licensing standards
7._____this patient should be evaluated by a specialist in another field for the purpose of determining safe driving. Type of specialist recommended: _____
(EX: Neurologist, Occupational Therapist, etc.)

Patient's First Name **Last Name** **Date of Birth**

ADDITIONAL INFORMATION

Please fill in all information below:

PRINT NAME OF QUALIFIED MEDICAL PROFESSIONAL	CLASSIFICATION/SPECIALITY	MEDICAL LICENSE #
MAILING ADDRESS (including city, state, zip)	CONTACT PHONE NUMBER	
FAX NUMBER		
AUTHORIZED SIGNATURE	DATE	

Should you have any questions regarding this form, please contact the Driver Licensing Program at 605-773-6883.

MAIL TO: **South Dakota Department of Public Safety**
Driver Licensing Program
118 West Capitol Avenue
Pierre, SD 57501

OR Fax to: 605-773-3018