Re: Customer No

Dear

It has become necessary for the Medical Review Section of the Division of Motor Vehicles to review your ability to continue to safely operate a motor vehicle.

The enclosed Medical Report Form should be completed by your physician and returned to the Division. It is important that this document be completed and returned to the Medical Review Unit within 30 days from the date of this letter to avoid the cancellation of your driving privilege.

Please give this matter your immediate attention in order to expedite your medical evaluation. If you have questions, you may contact us at (919) 861-3809 or fax number (919) 733-9569.

Sincerely,

Jeffrey R. Zimmerman, M.P.A.
Director of Processing Services

Enclosure
** IMPORTANT **

Instructions for Completing Medical Report

1. In order to process the attached form your signature is required.

2. Take this form to a physician licensed to practice medicine in the state of North Carolina or any state of the United States for completion. Your physician will only need to complete the appropriate part(s) of this form that pertain to your health.

3. Please mail the completed form to the Division of Motor Vehicles Medical Review Unit, 3112 Mail Service Center, Raleigh, NC 27699-3112.

This information is required to determine your ability to safely operate a motor vehicle. Failure to submit the required medical information within 30 days from the date of this letter, will result in cancellation or denial of your driving privilege. If additional time is needed you may contact this office for consideration.

TELEPHONE (919) 861-3809
FAX (919) 733-9569
NORTH CAROLINA DIVISION OF MOTOR VEHICLES
DRIVER LICENSE SECTION
CONSENT/INFORMATION FORM

Customer No.
Driver please complete the following:

Date of Birth ________ Race ___ Sex ___ County _______

I hereby authorize Dr./Counselor ___________________________ to give any
examination they deem necessary for the purpose of determining my physical
fitness to operate a motor vehicle. I understand this authorization
includes permission for this information to be reviewed by a medical
advisor approved by the division for the purpose of a recommendation to be
rendered to determine my driving needs and abilities.

SIGNATURE OF APPLICANT:

PARENT/GUARDIAN IF MINOR:

Telephone No.: Home (__) __________ Business(____)
Are you ___ Retired ___ Disabled ___ Occupation: ____________________________
What type of vehicle do you drive? Automobile _____ School Bus __________
Commercial Motor Vehicle _____ Other __________________________
Does your job require driving? ____________________________________________

To Physician

When completing the Medical Report Form, please keep in mind the physical,
mental and emotional requirements necessary for the safe operation of a
motor vehicle, for the patient and public welfare. Please answer all
questions and applicable parts of PP. 2-7, which list thereview of
conditions pertinent to driving. If you circle "Yes" for any of these
conditions, you should address all the questions pertaining on the
proceeding pages. You do not need to answer questions on the form for which
you circled "No". Upon completion of this form please make an overall
statement about your patient's medical condition and its potential effect
on safe driving.
CUSTOMER NO.

PATIENT'S MEDICAL HISTORY (Please complete in black ink):
A. If the patient has been hospitalized in the past two years, please give location, dates and discharge diagnoses. ____________________________________________________________
B. How long has applicant been your patient? ______________________________
   Date you last treated patient before today? ______________________________
C. Names of other physicians who have treated applicant in past two years:
D. What is patient's height? ________ weight? ________ B.P. ________
E. ARE YOU TREATING THIS PATIENT FOR ANY OF THE FOLLOWING MEDICAL
   CONDITION(S) IF YES, PLEASE COMPLETE APPROPRIATE PAGE(S)
   YES NO YES NO
   VISUAL IMPAIRMENT? ________ EMOTIONAL/MENTAL ILLNESS? ________
   If yes, p.3 to be completed by Optometrist or Ophthalmologist
   If yes, complete entire section p.5
   CARDIOVASCULAR DISORDER? ________ MUSCULOSKELETAL DISORDER? ________
   If yes, complete entire section p.4 If yes, complete entire section p.5
   ENDOCRINE DISORDER? ________ ANY OTHER IMPAIRMENT? ________
   If yes, complete entire section p.4 If yes, complete entire section p.5
   RESPIRATORY DISORDER? ________ SUBSTANCE ABUSE PROBLEM? ________
   If yes, complete entire section p.7 If yes, complete entire section p.6
   NEUROLOGIC DISORDER? ________
   If yes, complete entire section p.7
F. ANSWERED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THE U.S.:
   1. In your opinion, has the patient followed your medical recommendations?
      Yes ________ No ________
   2. Are periodic medical evaluations for highway safety purposes recommended for patient? Yes ________ No ________ If yes, how often?
   3. Do you feel the patient is medically fit to drive a car? Yes ________ No ________
   4. Do you feel the patient is medically fit to drive a CMV/SCHOOL BUS? Yes ________ No ________
   5. In your opinion, should patient be restricted to driving? If yes please specify ___ miles radius of home, 45 mph/no interstate, daylight driving only, hand controls, corrective lenses, left foot accelerator, wheel knob, accompanied by class driver, t/f wk/ch/md/store, etc.
   6. Do you recommend a road test? Yes ________ No ________
   7. Do you recommend a Occupational Therapist Evaluation? Yes ________ No ________
   8. Has the driver's medical condition contributed to any recent accidents? Yes ________ No ________

Give your overall assessment of this patient's medical condition and any potential effect on safe driving. Please comment on all medical conditions, and any over-the-counter or prescription medications that might exacerbate the risk of driving. ____________________________________________________________

Physician's Signature: ____________________________ MD, NP, PA Date of exam: ____________________________
Physician's Specialty: ____________________________
Physician's Name: (Print) ____________________________ Phone No. (____) ____________________________
Address: ____________________________ City/Zip: ____________________________

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I, _______________________, hereby authorize Dr. ______________________ to provide my examination information for the purposes of determining my visual fitness to operate a motor vehicle. I understand this authorizes the Division's panel of physicians to review my case.

Applicant Signature ___________________________ License/Cust No. ___________
Parent/Guardian if Minor ____________________ Telephone Number __________

TO BE COMPLETED BY A LICENSED OPHTHALMOLOGIST OR OPTOMETRIST

1. What is the vision diagnosis? ________________________________

2. Which eye(s) are affected? ______________________ Left ______ Both ______

3. Is the condition: Permanent Stable Worsening Improving

4. Best corrected Visual Acuity: 20/ ______ Both 20/ ______ Right 20/ ______ Left ______

5. Uncorrected Visual Acuity: 20/ ______ Both 20/ ______ Right 20/ ______ Left ______

6. New lenses prescribed? Yes ______ No ______

7. Are corrective lenses recommended to drive? Yes ______ No ______

8. What is the horizontal field of view in each eye w/out field expanders?
   Right: ______ nasal ______ temporal ______ Left: ______ nasal ______ temporal ______
   Test used: ______ Confrontation ______ Goldmann ______ Automated ______

9. Are there other visual issues that might affect driving?
   ______ No ______ Depth Perception ______ Diplopia ______ Contrast Sensitivity ______
   ______ Glare sensitivity ______ Other: ________________________________

10. Is a bioptic telescope used for driving? Yes ______ No (skip to #16)

11. If yes, how long has it been used? ______ New Duration: ______ mo/ys

12. If yes, for which eye(s)? (Circle) ______ Right ______ Left ______ Both ______

13. Visual acuity through bioptic telescope: ______ Right ______ Left ______ Both ______

14. Has the individual driven previously without a bioptic telescope? Y ______ N ______

15. Has the individual completed training in the use of a bioptic for driving? Y ______ N ______

16. Are there any other concerns regarding this individual's fitness to safely operate a motor vehicle? ______ No ______ Cognitive ______ Physical ______ Psychological ______ Other: ________________________________

17. What driving restrictions (if any) do you recommend based upon your examination? ______ None ______ 45mph limit/no interstate ______ Daylight Only ______ Local driving only: ______ miles from home ______ Should not drive ______

18. Other recommendations:
   ______ Periodic vision evaluation: ______ 6 months ______ every: ______ 1 ______ 2 ______ 3 ______ years(s) ______
   ______ On road evaluation by DMV (or approved examiner) ______
   ______ Recommend DMV follow-up? ______ Yes ______ No ______
   ______ Other: ________________________________

Vision Examiner:
Name ___________________________ Degree ______ License # ______
Address __________________________________________________________

Phone ___________________________ Fax ___________________________
Signature ___________________________ Date __________
CUSTOMER NO.

**************************************** CARDIOVASCULAR ****************************************

1. What is the diagnosis? __________________________
   Date of onset: _______________________________

2. Check AHA Cardiovascular Functional Class: I___ II___ III___ IV___

3. Does patient have arrhythmia that alters mental or physical functions?
   Yes ___ No ___ If yes, how often? __________________________
   What is the severity and does it cause syncope? __________________________
   Is it controlled? Yes ___ No ___

4. Does patient currently use a pacemaker? Yes ___ No ___

5. Does the patient currently use an automatic implantable cardioverter-
   defibrillator? Yes___ No___ If yes, give date of surgery _________
   Date(s) of hemodynamically significant arrhythmia events post-op: __________________________

6. Has the patient had cardiac surgery? Yes ___ No ___
   Date and type of operation __________________________

7. Has the patient had CHF? Yes ___ No ___
   Is CHF controlled? Yes ___ No ___

8. List current medications: __________________________

9. Assess compliance with medications: Excellent___ Good___ Poor___

**************************************** ENDOCRINE/DIABETES ****************************************

1. What is the diagnosis? __________________________
   Date of onset _________ HgbA1C Level _________ Therapy _________

2. If patient has experienced significant hypoglycemia in past year give
   dates of last episodes: __________________________

3. What is the patient's attitude toward treatment?
   Accepts and complies ___ Non-compliant ________

4. Does the patient have any current or past systemic effects of diabetes
   and if so comment on its effect on driving? __________________________

5. Is the patient aware of the early warning signs of hypoglycemia and are
   reliable in taking necessary precautions to avoid hypoglycemia? Yes ___ No ___

6. List current medications: __________________________

7. Assess compliance with medications: Excellent___ Good___ Poor___

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CUSTOMER NO.

************************** MENTAL OR EMOTIONAL **************************
1. What is the diagnosis? __________________________ Date of Onset ____________
2. When and where was patient treated for this condition? __________________________
3. What is patient’s current status? Recovered __ Partially Controlled __
   Intermittently Controlled __ Inadequately Controlled __ Fully Controlled __
4. Does patient have memory problems? Yes ___ No ___
   If yes, to what degree? Mild ___ Significant ___ Severe ___
5. What is patient’s mental capacity? Average or above ______
   Below Average ______ Limited ______
6. Do you believe that this patient’s mental or emotional illness poses a
   driving risk to himself/herself or others? Yes ___ No ___
7. List current medications:
8. Assess compliance with medications: Excellent ___ Good ___ Poor ___

************************** MUSCULOSKELETAL **************************
1. What is the diagnosis? __________________________ Date of Onset ____________
2. Describe extent of impairment and prognosis __________________________
3. Is it progressive? Yes ___ No ___
4. Indicate percent of function (full range of motion equals 100%)
   RIGHT ARM LEFT ARM RIGHT LEG LEFT LEG NECK
   % ___ % ___ % ___ % ___ % ___
5. Indicate percent of strength (full range of motion equals 100%)
   RIGHT ARM LEFT ARM RIGHT LEG LEFT LEG NECK
   ___ % ___ % ___ % ___ % ___
6. To what extent is coordination or reaction time impaired?
   None ___ Slight ___ Moderate ___ Severe ___
7. To what extent does patient’s motion produce pain?
   None ___ Slight ___ Moderate ___ Severe ___
8. What spastic muscles does patient have? __________________________
9. What extremities are missing?
10. Do you recommend any assistive devices to compensate for your patient
    disability? If so please advise: __________________________
11. Do you recommend an Occupational Therapist Evaluation? Yes ___ No ___
12. To what extent will the patient’s musculoskeletal disorder impair
    driving? None ___ Slightly ___ Significantly ___ Should not drive ___
    REMARKS: __________________________
13. List current medications: __________________________
14. Assess compliance with medications: Excellent ___ Good ___ Poor ___

************************** OTHER IMPAIRMENTS **************************
1. Are there other medical impairments? Yes ___ No ___
   If yes, describe: __________________________
2. List current medications: __________________________
3. Assess compliance with medications: Excellent ___ Good ___ Poor ___
Customer No

SUBSTANCE ABUSE

Notice: Recommendations for licensure for persons suspected of having substance abuse disorders will largely be made on the basis of their medical and other relevant records and documents.

1. Is the patient aware that driving with any amount of alcohol in their system is likely to affect driving performance and increase the risk of injury? Yes ___ No ___

2. Has the patient ever been charged with driving while impaired (DWI)? Yes ___ No ___ If yes, how many convictions? _________

3. At what age did the patient start drinking alcohol? ________

4. How often does (or did), patient drink?
   Daily ____ Weekly ____ Monthly ____ Binge ____

5. How much does (or did), patient drink at a time?
   1-2 drinks ____ 3-4 drinks ____ 5 or more drinks ____ Pint ____

6. How many times a year does (or did), patient drink enough to affect speech, walking, driving, or other activities? ________

7. Did the patient ever completely stop drinking? Yes ___ No ___
   If yes, give the date(s) length of time stopped: __________

8. What was the date of patient's last drink (beer, wine, whiskey)? ________

9. Has patient ever had a drinking problem? Yes ___ No ___

10. Does the patient believe that he/she can still drink without causing problems? Yes ___ No ___ If yes, why? ________

11. Has patient ever abused other drugs (illicit/prescription)? Yes ___ No ___
    If yes, give drugs and describe extent of usage: __________

12. Describe patient's current use of drugs and/or medications: ________

13. When did patient last abuse drugs?

14. Which of the following types of substance abuse education, treatment, or rehabilitation programs has patient SUCCESSFULLY COMPLETED?
   ___ ADETS (Alch. Drug Ed. Traffic Sch.) Dates: _______ to _______
   ___ Alcohol Rehabilitation Center Dates: __________ to __________
   Name: ________
   Mental Health Program Dates: _______ to _______
   Alcoholics Anonymous Dates: _______ to _______ Sponsor? Yes ___ No ___
   Approximate number of sessions: _______
   None: The patient did not complete a substance abuse program.

15. Have you recommended that this patient seek help? Yes ___ No ___

16. Is patient actively involved in any social or other type of health aid program such as mental health, private counseling, Alcoholics Anonymous, etc.? If yes, please complete the following:
   Name of program: ________
   Address: ____________________________ Telephone: (____)

17. Does the patient have sufficient support for maintaining sobriety? Yes ___ No ___

18. Is the patient using Methadone or Naltraxone? Yes ___ No ___
CUSTOMER NO

RESPIRATORY

1. What is the diagnosis?

Medications

2. What is the degree of severity? Mild _____ Moderate _____ Severe (pa02_60mmHg) _____ Debilitating _____

**NOTE: IF pa02 IS LESS THAN 60mmHg, PLEASE OBTAIN AND ATTACH ROOM AIR ARTERIAL BLOOD GAS IF NOT CONTRAINDIATED.

3. Does patient use oxygen while driving? Yes _____ No _____

4. Oxygen saturation levels

5. Does patient use a CPAP machine? Yes _____ No _____

**NOTE: If physician checked "YES" to question #5 please attach a copy of your CPAP COMPLIANCE REPORT FOR THE LAST YEAR**

NEUROLOGIC

1. What is diagnosis?

Date of onset:

2. Has patient suffered brain damage from trauma, cerebrovascular disease, stroke, or other cause? Yes ____ No ____ Has it resolved? __________

3. Has patient suffered impairment of any of the following:

Mentation? Yes ____ No ____ Memory? Yes ____ No ____

Judgment? Yes ____ No ____ Emotional Stability? Yes ____ No ____

**NOTE: IF YOU CHECKED "YES" TO ANY OF THE ABOVE CATEGORIES, COMPLETE THE EMOTIONAL PORTION OF THIS FORM.

4. Has patient suffered impairment of any of the following:

Muscular strength? Yes ____ No ____ Coordination? Yes ____ No ____

**NOTE: IF YOU CHECKED "YES" TO ANY OF THE ABOVE CATEGORIES, COMPLETE THE MUSCULOSKELETAL PORTION OF THIS FORM.

5. If patient has seizure disorder, what type?

With seizure, is there any loss of consciousness? Yes ____ No ____

Date of onset: ___________ Number of seizures in last 2 yrs: ___________

Date of last: ___________ Aura? If yes, duration: ___________

Does the seizure occur during sleep only? Yes ____ No ____

6. Is patient taking medication for his/her epilepsy or seizures?

Yes ____ No ____ If yes, complete the following:

List medications and dosage

Date of last medication change ___________ Blood levels ___________

Date medication was discontinued ___________ Who discontinued ___________

Compliance with medication: Excellent ____ Good ____ Poor ____

Interpretation: ___________________________

7. Has the patient had an EEG? Yes ____ No ____ If yes, when: __________________

Interpretation: ___________________________

8. Have there been other episodes of altered consciousness? Yes ____ No ____

If yes, give data, description and work-up: ___________________________
00 No physician-diagnosed disease of consequence
08 Automatic implantable cardioverter-defibrillator
11 Hypertension
12 Cardiovascular disorder - (CAD, MI, HCVD, OTHER)
13 Valvular heart disease and all congenital heart diseases
14 Cerebrovascular accidents (including ruptured aneurysms, etc.)
15 Cardiac arrhythmias
16 Peripheral vascular disease (non-cerebral)
17 Congestive heart failure
18 Pacemaker
19 Cardiac surgery-coronary by-pass, angioplasty, valvular replacement, etc.
20 Diabetes Mellitis, treated with insulin
21 Diabetes Mellitis, not treated with insulin
22 Diabetic Peripheral Neuropathy
25 Other endocrine disorders
30 Blackout spells, syncope, dizziness, vertigo, etc.
31 Seizure disorder (all types) - Grand mal, petit mal, ETC.
32 Narcolepsy, sleep apnea, and related disorders
33 Multiple sclerosis
34 Parkinson's disease
35 Other acquired neuromuscular disease (muscular dystrophy, other)
36 Other congenital neuromuscular disease (spina bifida, other)
37 Cerebral vascular malformations (A-V malformations, aneurysms, etc.)
38 Cerebral palsy
39 Paralysis - complete or partial, 2nd to trauma (CNS, cord injury, etc.)
40 Paralysis, complete or partial, of any other etiology
41 Head and/or brain trauma, sub-dural hematoma, etc.
42 Brain neoplasm or tumor (including acquired hydrocephalus)
45 Arthritis, rheumatism and bursitis
46 Absent extremity(ies) or part(s) thereof
47 Non-paralytic back impairments (including cervical spine)
48 Other impairments involving bones, joints, and/or muscles
50 Hearing impairments
55 Visual defects-general (macular degeneration, amblyopia, trauma, other)
56 Cataracts (incl post op), corneal scars, Fuch's corneal dystrophy, etc.
57 Visual field changes (including optic atrophy, glaucoma, retinitis, etc)
58 Retinitis pigmentosa, Sagarts's Retinitis
59 Nystagmus
60 Emotional or mental illness (simple depression, other)
61 Schizophrenia and schizoid disorders - paranoid, chronis, undifferentiated
62 Bi-polar disorders (manic and/or depressive) with/without psychosis
63 Neurotic disorders (anxiety, panic, hysteria, conversion, phobias)
64 Personality disorder (borderline, passive aggressive, other)
65 ALCOHOL-RELATED - ALL CASES CODED PRIOR TO 7/1/69
66 Alcohol related-no record of DWI or evidence of drinking while driving
67 Alcohol related-convicted DWI or evid drink whl dri, abstinent 18 mos
68 Alcohol related-convicted DWI or evid drink whl dri, NOT abstain 18 mos
70 Illegal and/or improper drug use contraindicatind driving
75 Mental deficiency
76 Organic brain syndrome (of any etiology)
77 Poor driving ability, high risk driver
78 Alzheimer's disease
80 Respiratory disorders
90 Miscell diseases/impairments(specify-renal, anemia, cancer, obesity, etc)
99 General Physical Condition