



Mama Lucy Kibaki Hospital

CUSTOMER INFORMATION						
NAME (Last) (First) (Mi) (Suffix)			CUSTOMER NUMBER (from your driver's license) or SSN			
RESIDENCE HOME ADDRESS			<input type="checkbox"/> Check if this is a new address, your address will be changed on DMV's system.			
CITY		STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE		
MAILING ADDRESS (if different from above)						
CITY			STATE	ZIP CODE	DAYTIME TELEPHONE NUMBER	
BIRTH DATE (mm/dd/yyyy)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	WEIGHT lbs		HEIGHT FT	IN	
Describe, in detail, your medical condition.						
Do you take prescription/non-prescription medications? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, list below. (attach a separate sheet if more space is required)						
NON-PRESCRIPTION MEDICATION	DOSEAGE	TIME(S) TAKEN	PREScription MEDICATION	DOSEAGE	TIME(S) TAKEN	
Have you ever experienced a blackout, seizure, loss of consciousness, or syncope? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, enter date of last episode.			DATE (mm/dd/yyyy)		Did the episode result in a motor vehicle crash? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Explain what happened during the episode.						
COMMERCIAL DRIVER LICENSE DISABILITY WAIVER OR HAZARDOUS MATERIALS VARIANCE Are you applying for a commercial driver license disability waiver or a hazardous materials variance? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, a CDL Disability Waiver or Hazardous Materials Variance Application (MED 30) must also be submitted.						
INFORMATION RELEASE APPROVAL						