Fitness to Drive Form

Last Name	First Name	Middle Name	Date	Birthdate	Age	Sex

Street Address	City, State, Zip	Phone No. (Home)	Phone No. (Work)	Email

Application Type	Driver's License No.	State	Examination Standards	License Class
❑New License ❑Existing License			❑Personal License ❑Commercial License	❑ A ❑ C ❑ B ❑ D

Medical History

Injury/Illness in past two years	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Stroke/Paralysis	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Seizures/Epilepsy	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Hearing Disorder(s)	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Vision Disorder(s)	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Heart Condition(s)	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Muscular Spasms/Disease	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Spinal Injury/Disease	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Amputations	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Asthma/Fainting	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Substance Use	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Current Medication(s)	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Recent Surgeries	❑ No	❑ Yes	❑ Unknown	If yes, explain:	
Other	❑ No	❑ Yes	❑ Unknown	If yes, explain:	

Reviewer Decision	Action Required
❑ The applicant is qualified for a [personal/commercial] license without further assessment.	None.
❑ The applicant is qualified for a conditional [personal/commercial] license.	
❑ The applicant is not qualified for a [personal/commercial] license without further assessment.	
❑ The applicant is not qualified for a [personal/commercial] license.	

Signature _____ Date _____