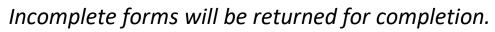
## ALTERNATIVE VEHICLE DRIVER PHYSICAL EXAMINATION REPORT





Applicant Name		Drivers License Number	Date of Birth		
Home Address	City	State Zip	Phone Number		
The following sec	tion is to be completed by the Applicant	and the Health Care Professional.			
Section A	ADDITCANT: Complete Section A	HEALTH CADE	DPOEESSIONAL: Complete Section B	Section B	
Yes No	APPLICANT: Complete Section A	HEALTH CARE	PROFESSIONAL: Complete Section B	Yes No	
163 140	Alcohol or other drug abuse or depende	ency within the past 12 months		165 110	
	Alcohol or other drug abuse or dependent	· · · · · · · · · · · · · · · · · · ·	ns not controlled by treatment		
	Neuro/Muscular disease, e.g., ALS, MS,				
	Diabetes or elevated blood sugar control		PillsInsulin		_
	Heart disease or heart attack, stroke, or		Nato.		
	Heart surgery (valve replacement/bypa Pulmonary disease or condition, positive				
	Required oxygen use	e 15 communicable form, empirys	Jema, eer b		
	Sleep disorders, pauses in breathing wh	nile asleep, daytime sleepiness, lou	ud snoring		
	Loss of body control, or altered conscio				
	• • •	episode			
	Kidney disease, dialysis	rovido 2 RD roadings takon ovor a 1	2 week period, separated by at least 1 day)		
	Mental/emotional condition(s)	ovide 3 brileadings taken over a 2	week period, separated by at least 1 day)		
	Missing or impaired hand, arm, foot, le	g			_
N/A N/A	Inability to hear instructions given in no		Corrected by hearing aid		
N/A N/A	Any medication that would interfere wi	th the safe operation of a vehicle			
Annlicant: Compl	ete the information below				
	ers, indicate onset date, diagnosis and any	current limitations in the space pr	rovided below. List all medications		
-	e-counter medications) used regularly or r	•			
Leartify that the a	nswers and statements made on this reno	rt are true and correct I authorize	e the examining health care professional to		
•	s of an examination upon request to the So		e the examining health care professional to		
A I' I C' I			<b>D</b> . 1:		
Applicant Signatu	re essional: Complete the information below	•	Date		
	ers above, indicate onset date, diagnosis a		medications (including over-the-counter		
•	regularly or recently. Please use the back	•			
ŕ	,				
Would you recom	mend an additional medical evaluation?				_
Trouta you recom	mena an additional medical evaluation.				
4 1 100					
Additional Commo	ents:				
-	be based on an examination that was cor nsece to practice	nducted in the past 12 months. I demonstrated in the past 12 months in the past 12 mon	certify that I have examined this applicant C).		
<b>Practioner Name</b>	(Print)	Patient Examination Date	Office Phone Number		
		Medical License Number Nat	tional Registry Number - Chiropractor Only		$\dashv$
v					
Λ					

Authorized Signature

Form Updated: 6/1/2023