Driver's Medical Certificate

Transportation and Public Works, Highway Safety Division

PO Box 2000, Charlottetown, PE C1A 7N8
Tel: 902 368 5210
Fax: 902 368 5236

PO Box 2063, Summerside, PE C1N 5L2
Tel: 902 432 2714
Fax: 902 888 8306

This certificate is to be used to record the results of a medical examination by a physician on behalf of an application for a driver's licence issued pursuant to the *Highway Traffic Act* and Regulations.

Pursuant to Section 70(6) of the *Highway Traffic Act*, the Registrar may, before issuing a driver's licence, or anytime after he has issued the licence to the person, require the person to undergo a medical examination and produce a certificate on such form as the Registrar may provide to determine whether the person is physically and mentally competent to operate a motor vehicle or any class of motor vehicle.

In determining whether or not a person is medically fit to operate a motor vehicle, the Registrar and Highway Safety Medical Review Board shall apply the standards set out in the most recent edition of the Medical Standards for Drivers manual published by the Canadian Council of Motor Transport Administrators.

Important Note: The costs associated with the completion of this report are the responsibility of the driver/patient.

Personal information on this form is collected under Sections 13 and 70 of Prince Edward Island's *Highway Traffic Act* and will be used for the purposes of the issuance of driver and/or vehicle permit(s) to the applicant. Information which is collected, as it relates to and is necessary for the operation of a Single Window Access Technology system, will be used, pursuant to Section 31 (C) of the *Freedom of Information and Protection of Privacy Act*, in the provision of government programs and services to the applicant. If you have any questions about this collection of personal information, you may contact the Department of Transportation and Public Works, Registrar of Motor Vehicles, PO Box 2000, Charlottetown, PE C1A 7N8 – Telephone: (902) 368-5223.

PART I – DRIVER/PATIENT INFORMATION

Name ______________________ Driver's Licence # ______________________

Address ______________________ Date of Birth ______________________

______________________ Telephone (home) ( ) ______________________

Postal Code ______________________ (work) ( ) ______________________

Reason ____

Issuing Person ______________________ Date ______________________

This certificate is submitted in support of my application to obtain or retain the following class of driver's licence.

Class 1 ○ (tractor-trailer)	Class 2 ○ (bus/school bus)	Class 3 ○ (straight truck)	Class 4 ○ (ambulance/bus/taxi)	Class 5 ○ (passenger car/light truck)
Class 6 ○ (motorcycle)	Class 7 ○ (instruction permit)	Class 8 ○ (moped)	Class 9 ○ (farm tractor)	Other ○ Specify: ______

Driver's Certificate of Information and Release for Physician to Report Medical Information

I certify that the foregoing information is, to the best of my knowledge, correct. I further authorize any physician, hospital or medical clinic to release to the Registrar any information concerning my medical condition.

______________________ ______________________
Signature of Driver/Patient Date

COMMERCIAL VEHICLE DRIVERS

Effective March 31, 1999, Canadian commercial vehicle drivers will no longer be required to carry a medical card for inspection by US officials as proof of medical fitness. Canada and the US have agreed to the following prohibitions:

1. Insulin-dependent diabetics will not be qualified to operate in the US.
2. Hearing-impaired drivers in Canada who do not meet the US standard will not be qualified to operate a commercial vehicle in the US.
3. Canadian drivers who have a diagnosis of epilepsy will not be qualified to operate a commercial vehicle in the US.

(2004) 06TR15-13408

PART 2 – VISION

A – VISUAL ACUITY

Highway Safety/Access PEI First Reading		Physician's/Optometrist's Initial Findings	
Right eye	20/____	Right eye	20/____
Left eye	20/____	Left eye	20/____
Both eyes	20/____	Both eyes	20/____

Initials ______ Date ______

Highway Safety/Access PEI Second Reading		Physician's/Optometrist's New Findings	
Right eye	20/____	Right eye	20/____
Left eye	20/____	Left eye	20/____
Both eyes	20/____	Both eyes	20/____

Initials ______ Date ______

B – FIELD OF VISION – Optometrist/Ophthalmologist

Yes	No	
O	O	(a) For classes 5, 6, 7, 8 and 9, is field less than 120° with both eyes open and examined together? **or**
O	O	(b) For classes 1, 2, 3 and 4, is field less than 150° with both eyes open and examined together?
O	O	Colour blindness? (cannot accurately identify red, green and amber)
O	O	Abnormal depth perception? (binocular vision)
O	O	Diseases of the eye? If "*yes*", please explain ______

______

______

______

Yes	No	
O	O	Progressive defects? At what length of time, in your opinion, might such defects have progressed to a point where re-examination would be indicated in the interest of highway safety?

______

Based upon my examination, it is my decision that the visual performance of the above applicant IS ( ) IS NOT ( ) adequate to operate a motor vehicle with due regard for public safety.

Please indicate if a new prescription is required.
Yes O No O

O General Practitioner
O Ophthalmologist
O Optometrist

______
Signature

Date ______

PART 3 – MEDICAL HISTORY/PHYSICAL EXAMINATION

A – SUBSTANCE ABUSE

Yes	No	
O	O	Is there a diagnosis of chronic abuse or dependence on alcohol or other substance?

If "*yes*", please specify ______

______

______

Yes	No	
O	O	If "*yes*", is the problem under control?
O	O	If "*yes*", has control been maintained for the last 12 months?

B – PRESCRIPTION DRUG(S)/MEDICATION(S)

Yes	No	
O	O	Is the patient taking any drug(s)/ medication(s) that would cause impairment of driving ability?

If "yes", please identify drug(s) (name and dosage) ______

______

______

______

______

______

______

______

C – CEREBROVASCULAR DISEASES

Is there a current history or evidence of:

Yes	No	
O	O	Cerebrovascular accidents including TIAs
O	O	Aortic aneurysm
O	O	Cerebral aneurysm
O	O	Peripheral arterial vascular disease
O	O	Diseases of the veins
O	O	Hospitalizations, if any, within the last five years for any conditions?

______

______

______

D – HEARING LOSS

Yes	No	
O	O	Is there any significant degree of hearing loss? If "*yes*", and the applicant is a commercial driver, please provide decibel reading.

____

____

E – MENTAL DISORDERS

Yes	No	
O	O	Is there a current history or evidence of cognitive disorders (dementias)?
O	O	If "*yes*", is judgment impaired sufficiently to affect driver's abilities?
O	O	Is there a current history or evidence of an emotional disorder likely to severely affect judgment or psychomotor ability?

F – DISEASES OF THE NERVOUS SYSTEM

Yes	No	
O	O	Is there a recent history of single unexplained or recurrent syncopal episodes? If "*yes*", please provide satisfactory neurological and cardiovascular assessments.
O	O	Is there a history of seizures within the past 10 years? If "*yes*", when was the most recent seizure? _______________
O	O	Was this a case of unprovoked seizure?
O	O	Is there a normal neurological assessment with an EEG revealing no epileptiform activity?
O	O	Is medication required to maintain seizure control? Dosage _______________
O	O	Have medications been discontinued on physician's advice? If "*yes*", when? _______________
O	O	Is there a history of other disease of the nervous system? (Narcolepsy, sleep apnea, vestibular disorders, disorders of coordination and muscle control, head injury, or intracranial tumour, etc.)

If "*yes*", please explain _______________

____

____

(Attach neurologist's report.)

G – MUSCULOSKELETAL DISABILITIES

Yes	No	
O	O	Is there evidence of musculoskeletal condition such as amputation, arthritis, disease of the spine etc. likely to impair ability to operate a motor vehicle safely?

If "*yes*", please explain _______________

____

H – CARDIOVASCULAR DISEASES

Yes	No	
O	O	Coronary artery disease
O	O	Myocardial infarction If "*yes*", date of last attack _______________ Please explain _______________ _______________
O	O	Heart transplant

If "*yes*" to any of the above, what is the **"functional classification"** (Canadian Cardiovascular Society)?

O CCS Class 1 O CCS Class 2
O CCS Class 3 O CCS Class 4

Yes	No	
O	O	Congestive heart failure
O	O	Cardiac arrhythmia
O	O	Valvular heart disease
O	O	Cardiomyopathy
O	O	Mitral valve prolapse
O	O	Abnormal blood pressure

(Attach stress tests if applicable.)

I – RESPIRATORY DISEASES

Yes	No	
O	O	Is there a current history or evidence of moderate or severe respiratory impairment?

____

Blood Pressure Height Weight

J – PSYCHIATRIC DISORDERS

Yes	No	
O	O	Is there a current history or evidence of a personality disorder manifesting in antisocial, erratic or aggressive behaviour? If "*yes*", has there been a favourable psychiatric assessment? *Please enclose if available.*
O	O	Is there a current history or evidence of psychotic illness?
O	O	If "*yes*", is judgment impaired sufficiently to affect driver's abilities?

K – METABOLIC DISEASES

To be completed by the physician and reviewed in person with the applicant with diabetes.

Yes	No	
O	O	Is there a diagnosis of diabetes mellitus? Type(s) of driving: O local only O inter-city O inter-provincial O international
O	O	Is the applicant employed?
O	O	Have you attended a formal diabetes education program? If "*yes*", please indicate year ________ *Please provide proof of attendance.* Type of diabetes: O Type I O Type II Treatment? O diet only O insulin O oral medication
O	O	Are you knowledgeable about diabetes, including the effect of diet, physical activity, insulin dose and alcohol on your blood glucose levels?
O	O	Are you willing and able to eat on a regular basis at appropriate times (meals and snacks) before operating a motor vehicle and when on the road?
O	O	Are you willing and able to accurately check capillary sugars on a regular basis, before operating a motor vehicle and approximately every four hours when on the road?
O	O	Are you willing to stop driving and eat when glucose level is less than 6 mmol/1?
O	O	Are you willing to discuss any problems about diabetes or hypoglycemia (low blood sugar reactions) with your doctor?
O	O	Are you able to recognize warning symptoms of hypoglycemia and take appropriate action?
O	O	Are you willing to have a source of glucose (sugar) immediately available at all times when on the road?
O	O	Are you subject to "hypoglycemic unawareness" (severe low blood sugar reaction without warning which results in confusion, unconsciousness or convulsions, and which requires intervention by another person)? If "*yes*", indicate frequency? ________ When was the last episode? ________________________

K – METABOLIC DISEASES *(continued)*

Please describe how the last episode happened and the circumstances at the time:

____

____

____

Yes	No	
O	O	Are you willing to review your driving schedule with your doctor to make sure it is compatible with your meal plan and your insulin regimen?

PART 4 – RECOMMENDATIONS RESPECTING MEDICAL FITNESS TO OPERATE A MOTOR VEHICLE

Date of examination ________________________

How long has the applicant been your patient? ________

As a result of this examination, I recommend the following:

- O **Issue the class of licence applied for without restriction.**
- O **Do not issue licence without further medical examination.**
- O **Do not issue licence without driver's examination.**
- O **The applicant is not medically fit to drive any class of vehicle.**
- O **Issue a Class 5 licence only.**

Please enclose any reports or comments you feel appropriate.

____

____

____

____

____

____

Physician's signature

Print physician's name ________________________

Address ________________________

Postal code ________________________

Telephone (   ) ________________________

Facsimile (   ) ________________________

O Family physician, or
O Certified specialist in ________________________