Reset

New Nouveau Brunswick

DEPARTMENT OF PUBLIC SAFETY
LICENSING & RECORDS BRANCH

78-9282 (9/01)

MEDICAL FITNESS REPORT

*** Fee for examination is the responsibility of the licence applicant.**

This form is to be completed by a licensed medical practitioner. A positive response must be elaborated upon at the bottom of the form. *The physician's stamp must be affixed in the space provided.*

Name of applicant _____ Date of Birth _____

Address _____

Licence Number | | | | | | | | Class of licence applied for _____

Does the patient have a history or diagnosis of any of the following:

1. Any loss or impairment of limbs or extremities or other structural defect, limitation of mobility or co-ordination likely to interfere with the safe operation of a motor vehicle? **Yes** ☐ **No** ☐
2. Any impairment of the musculo-skeletal or nervous system likely to interfere with the safe operation of a motor vehicle? **Yes** ☐ **No** ☐
3. Diabetes mellitus which requires **either insulin or oral agents** for control? **Yes** ☐ **No** ☐
4. Myocardial infarction, angina pectoris, coronary insufficiency or thrombosis? **Yes** ☐ **No** ☐

   If first incidence, is the patient fully recovered? **Yes** ☐ **No** ☐
5. Heart or lung disease including arrhythmia or respiratory dysfunction? **Yes** ☐ **No** ☐
6. Hypertension accompanied by postural hypotension resulting in giddiness when under treatment? **Yes** ☐ **No** ☐
7. Requirement for hearing assistance? **Yes** ☐ **No** ☐
8. Loss of consciousness or awareness due to a chronic or recurring condition? **Yes** ☐ **No** ☐
9. Continuous use of any prescribed drug which could, in the dosage prescribed, impair ability to operate a motor vehicle? **Yes** ☐ **No** ☐
10. Clinical diagnosis of alcoholism or drug addiction? **Yes** ☐ **No** ☐
11. Established medical evidence of a sustained psychiatric disorder with particular regard to depression, suicidal tendencies or impulsive aggressive behaviour? **Yes** ☐ **No** ☐
12. Any other physical or mental impairment, disease or condition which is likely to significantly interfere with the individual's ability to operate a motor vehicle safely? **Yes** ☐ **No** ☐

Driver Examiner's Use only

VISION SCREENING

WITHOUT LENSES _____

WITH LENSES _____

EXAMINER _____

AUTHORIZED TRAINING

FOR CLASS _____

UNTIL _____

DD /MM /YY

_____

EXAMINER

DATE _____

VALID FOR N.B., P.E.I., N.S.

Office Stamp

Question	Remarks

This is to certify that I examined the above named applicant on

Date _____

and that this individual has been my patient since

Date _____

Examining Physician
Name (Print)

_____

Address _____

_____

Signature X _____

Physician's Stamp

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