

The personal information on this form is being collected under the authority of s. 26 of the *Freedom of Information and Protection of Privacy Act* and s. 25 or s. 29 of the *Motor Vehicle Act* for the purpose of determining your fitness to drive a motor vehicle and to allow your medical practitioner to bill the Medical Services Plan for the service. If you have any questions about the collection of your personal information please see the contact information in the "To the driver" section of the Instructions.

AREA ABOVE FOR OFFICE USE

DRIVER AND PHYSICIAN OR NURSE PRACTITIONER - SEE BACK FOR INSTRUCTIONS

PERSONAL HEALTH NUMBER

MSP Fee Code 96220

REASON FOR EXAMINATION AND CLASS

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This report should focus on the condition(s) stated above.

- For sections A and B, provide full information on the area(s) that, in your opinion, apply to the condition(s) being monitored and use section D as needed.
- Section C must be completed.

A. HISTORY (Reference to the 2010 BC Guide to Drive in Determining Fitness to Drive: Web links are provided on the back of form)

VISION (section 2 of Physician's Guide) <input type="checkbox"/> Acuity loss <input type="checkbox"/> Field defect <input type="checkbox"/> Eye disease <input type="checkbox"/> Other _____	CARDIOVASCULAR (sections 4 and 6) <input type="checkbox"/> Syncope Date _____ Cause _____ <input type="checkbox"/> CAD (M.I., angioplasty, CABG) Date _____ <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Pacemaker <input type="checkbox"/> Implanted defibrillator Date _____ <input type="checkbox"/> Congestive heart failure: _____ NYHA Functional Class _____ LVEF _____ <input type="checkbox"/> Aneurysm Site _____ Size _____ <input type="checkbox"/> Peripheral Vascular disease <input type="checkbox"/> Other _____	CNS (sections 5 and 7) <input type="checkbox"/> CVA/TIA Date _____ <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Provoked <input type="checkbox"/> Epilepsy Date of last seizure _____ <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Congenital condition (Cerebral palsy, etc.) <input type="checkbox"/> Progressive deficit (Parkinson's, MS, ALS, etc.) <input type="checkbox"/> Stable deficit (Paraplegia, Nerve damage, etc.) <input type="checkbox"/> Cognitive impairment MMSE/MOCA score _____ <input type="checkbox"/> Significant head injury <input type="checkbox"/> Other _____	RESPIRATORY (section 8) <input type="checkbox"/> Oxygen required when driving <input type="checkbox"/> Sleep apnea <input type="checkbox"/> CPAP compliant <input type="checkbox"/> Epworth Score _____ <input type="checkbox"/> Other _____
HEARING (section 3) <input type="checkbox"/> Hearing loss <input type="checkbox"/> Vertigo <input type="checkbox"/> Other _____	PSYCHIATRIC (section 12) <input type="checkbox"/> Psychosis <input type="checkbox"/> Severe depression <input type="checkbox"/> Impaired judgment, insight <input type="checkbox"/> Medication non-compliance <input type="checkbox"/> Stable Psych condition <input type="checkbox"/> Other _____	DRUGS AND ALCOHOL (sections 13 and 14) <input type="checkbox"/> Alcohol or drug abuse in past-2 years <input type="checkbox"/> Alcohol related seizure <input type="checkbox"/> Addiction rehab taken <input type="checkbox"/> refused <input type="checkbox"/> Prescribed drugs that could impair <input type="checkbox"/> Psychoactive drugs <input type="checkbox"/> Narcotics <input type="checkbox"/> Other _____	ENDOCRINE (section 9) <input type="checkbox"/> Diabetes Insulin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Severe hypoglycemia Date _____ <input type="checkbox"/> Hypoglycemia unawareness Date _____ <input type="checkbox"/> Stable BG Control <input type="checkbox"/> Compliant w/ Treatment HbA1C _____ Date _____ <input type="checkbox"/> Other _____
MUSCULOSKELETAL (section 11) <input type="checkbox"/> Amputation <input type="checkbox"/> Weakness <input type="checkbox"/> Range of motion loss <input type="checkbox"/> Other _____	OTHER CONDITIONS <input type="checkbox"/> General debility or functional decline <input type="checkbox"/> Other (see guide) _____		

B. VISION SCREENING AND PHYSICAL FINDINGS AFFECTING DRIVING May include EVF/VFT done within one year if available.

VISUAL ACUITY <input type="checkbox"/> Uncorrected R _____ L _____ Both _____ <input type="checkbox"/> Corrected R _____ L _____ Both _____	VISUAL FIELD <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Both visual acuity and visual field meet Physician's Guide criteria for licence class <input type="checkbox"/> YES	Blood Pressure _____
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C. OPINION Having completed A & B as applicable, in your opinion, does patient have a condition that may affect driving:

NO
 YES
 May in future - recommend follow-up in _____ years

D. DETAILS OF CONDITION(S) THAT AFFECT OR MAY AFFECT DRIVING May include relevant specialists' reports or lab results.

E. RECOMMENDATION(S)

Specialist Consult - Type _____
 Enclosed: Yes No I will arrange: Yes No
 Road test to assess _____
 Restrictions (Reason & Type) _____

F. DRIVER'S CERTIFICATION AND CONSENT TO RELEASE INFORMATION

- I certify that the information I have given to the Physician or Nurse Practitioner completing this report is to the best of my knowledge true and complete.
- I understand that inaccurate, misleading, missing or false information may lead to denial or cancellation of my driver's licence.
- I authorize the release of this medical report and all past or future reports pertaining to diseases, disabilities and conditions that may affect driving to the Superintendent of Motor Vehicles.

Patient's Signature	Date
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G. RELATIONSHIP WITH PATIENT

- Family physician or NP for _____ years
 Locum Walk-in First Visit NP Specialist

EXAMINING PHYSICIAN'S OR NP'S NAME AND ADDRESS <small>(Print Name or use rubber stamp)</small>	Examination Date Physician's or NP's Signature
TELEPHONE NO.	

INSTRUCTIONS

NOTE TO DRIVER AND PHYSICIAN OR NURSE PRACTITIONER (NP):

The Superintendent of Motor Vehicles (RoadSafetyBC) has arranged that physicians may bill the Ministry of Health, through the Teleplan billing system, \$75 to complete this form. RoadSafetyBC will reimburse Teleplan for such charges.

RoadSafetyBC has no authority to set the fee physicians or nurse practitioners charge. Physicians are entitled to set their own fee and to bill patients directly for either their full fee or any portion of the fee that exceeds the \$75 the physician may bill through Teleplan.

RoadSafetyBC will accept a DME completed by any qualified medical practitioner in British Columbia.

To the driver:

- Under section 25 or 29 of the *Motor Vehicle Act* the Superintendent of Motor Vehicles requires you to have this form completed because you have disclosed a driving-related medical condition; it is time to review the status of a previously identified driving-related medical condition; or a report has been received from a medical professional, police officer, or other person reporting a possible medical condition that may affect driving about which more information is required. Refer to the **“REASON FOR EXAMINATION AND CLASS”** on the front of the form.
- This form must be completed and returned by your physician or NP to the Superintendent of Motor Vehicles within 45 days. If medical approval is required prior to obtaining a licence for any class, you will be unable to obtain that licence until the completed form is submitted and approved. If this medical examination is required for a class of licence you already have, your driver's licence may be cancelled if you fail to have the form completed and submitted by your physician or NP within 45 days. This means you will be unable to drive until the form is submitted and you are issued a new driver's licence.
- If you are currently prohibited from driving, this medical report must be completed and returned by your physician or NP before your driving privilege can be considered for reinstatement.
- If you do not wish to retain your present class of driver's licence, please present this report uncompleted and your driver's licence to the nearest ICBC Driver Licensing Office.
- If you have a medical condition that may relapse, recur or deteriorate, you may have to take future medical examinations.
- You will be notified in writing **only if there is a change in your driver's licence status or if the Superintendent of Motor Vehicles requires further information.**
- If you have any questions about the collection of your personal information you may contact the RoadSafetyBC branch at PO Box 9254 Stn Prov Govt, at 250-387-7747 or toll-free at 1-855-387-7747.

To the examining physician or NP:

- It is essential to note the “Reason for Examination” and class of licence on the front of this form prior to completion.
- Refer to the “BC Driver Fitness Handbook for Medical Professionals” which can be found at <http://www.pssg.gov.bc.ca/osmv/shareddocs/DriverFitnessMedPro.pdf> . Additional driver medical fitness information, including a link to full text version of the 2010 B.C. Guide in Determining Fitness to Drive, can be found by visiting <http://www.pssg.gov.bc.ca/osmv/medical-fitness/> .
- Provide details of any medical conditions and medications that may affect driving in part D.
- Fax or mail the completed form as instructed on the front of this form. If you mail, you may wish to make a copy for your records.
- The fee code to submit for Teleplan billing is on the front of the form. Ensure the 7-digit driver's licence number is entered.

BRITISH COLUMBIA DRIVER LICENCE CLASSIFICATIONS Quick Check Chart

(Guide only - see *Motor Vehicle Act Regulations* for official purposes)

Class	Permits Operation of:
1	Any motor vehicle or combination of motor vehicles, except motorcycles
2	All class 5 vehicles plus all public passenger-carrying vehicles
3	All class 5 vehicles plus any motor vehicle with 3 or more axles, but not public passenger-carrying vehicles; towed vehicles cannot exceed 4600 kg
4 unrestricted	All class 5 vehicles, plus an ambulance, taxi, or school bus, special activity bus with seating capacity of not more than 25 persons, including driver
4 with restriction 17	All class 5 vehicles, plus an ambulance, taxi or special vehicle with a seating capacity of 10 or less
5 and 7	Any 2-axle motor vehicle, other than motorcycle, motorhomes, construction vehicles, may tow vehicles up to 4600 kg
6 and 8	Motorcycles, all terrain cycles or vehicle

RESTRICTION / ENDORSEMENT DEFINITIONS

11	QUALIFIED SUPERVISOR REQUIRED	23	HEARING AID REQUIRED FOR CLASS 1, 2, 3, OR 4 OR FOR ENDORSEMENT 18/19
12	RESTRICTED TO DAYLIGHT HOURS ONLY	24	CLASS 6 OR 8 RESTRICTED TO MOTOR SCOOTERS
13	CLASS 6 OR 8 NOT PERMITTED TO CARRY PASSENGERS	25	FITTED PROSTHESIS / LEG BRACE REQUIRED
14	NO HWY 99 S, OR VAN, OR HWY 1 E. OF VAN. OR W. OF HWY 9	26	SPECIFIED VEHICLE MODIFICATIONS REQUIRED
15	PERMITTED TO OPERATE VEHICLES WITH AIR BRAKES	28	RESTRICTED TO AUTOMATIC TRANSMISSION
16	NOT PERMITTED TO OPERATE CLASS 2 OR 4	35	NOT PERMITTED TO EXCEED 60 KM/H
17	NOT PERMITTED TO OPERATE BUSES	36	NOT PERMITTED TO EXCEED 80 KM/H
18	PERMITTED TO OPERATE SINGLE TRUCKS WITH AIR BRAKES ON INDUSTRIAL ROADS	37	NOT PERMITTED TO TRANSPORT DANGEROUS GOODS
19	PERMITTED TO OPERATE TRUCK TRAILER WITH AIR BRAKES ON INDUSTRIAL ROADS	42	QUALIFIED SUPERVISOR REQUIRED, ONE PASSENGER ONLY
20	PERMITTED TO OPERATE TRUCK TRAILER OF ANY GVW WITHOUT AIR BRAKES	43	RESTRICTED TO 5:00AM TO MIDNIGHT ONLY
21	CORRECTIVE LENSES REQUIRED	44	NO OPERATION OF MOTOR VEHICLE WITH ALCOHOL IN BODY, MUST CLEARLY DISPLAY OFFICIAL NEW DRIVER SIGN

The personal information on this form is being collected under the authority of s. 26 of the *Freedom of Information and Protection of Privacy Act* and s. 25 or s. 29 of the *Motor Vehicle Act* for the purpose of determining your fitness to drive a motor vehicle. If you have any questions about the collection of your personal information please see the contact information in the "To the driver" section of the Instructions.

AREA ABOVE FOR OFFICE USE

DRIVER AND PHYSICIAN OR NURSE PRACTITIONER - SEE BACK FOR INSTRUCTIONS

REASON FOR EXAMINATION AND CLASS

- Driver requires a complete physical examination.**
- **Sections B and C must be completed.**
 - **Use sections A and D to provide details of any condition(s) that in your opinion may affect driving.**

A. HISTORY (Reference to the 2010 BC Guide to Drive in Determining Fitness to Drive: Web links are provided on the back of form)

VISION (section 2 of Physician's Guide) <input type="checkbox"/> Acuity loss <input type="checkbox"/> Field defect <input type="checkbox"/> Eye disease <input type="checkbox"/> Other _____	CARDIOVASCULAR (sections 4 and 6) <input type="checkbox"/> Syncope Date _____ Cause _____ <input type="checkbox"/> CAD (M.I., angioplasty, CABG) Date _____ <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Pacemaker <input type="checkbox"/> Implanted defibrillator Date _____ <input type="checkbox"/> Congestive heart failure: _____ NYHA Functional Class _____ LVEF _____ <input type="checkbox"/> Aneurysm Site _____ Size _____ <input type="checkbox"/> Peripheral Vascular disease <input type="checkbox"/> Other _____	CNS (sections 5 and 7) <input type="checkbox"/> CVA/TIA Date _____ <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Provoked <input type="checkbox"/> Epilepsy Date of last seizure _____ <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Congenital condition (Cerebral palsy, etc.) <input type="checkbox"/> Progressive deficit (Parkinson's, MS, ALS, etc.) <input type="checkbox"/> Stable deficit (Paraplegia, Nerve damage, etc.) <input type="checkbox"/> Cognitive impairment MMSE/MOCA score _____ <input type="checkbox"/> Significant head injury <input type="checkbox"/> Other _____	RESPIRATORY (section 8) <input type="checkbox"/> Oxygen required when driving <input type="checkbox"/> Sleep apnea <input type="checkbox"/> CPAP compliant <input type="checkbox"/> Epworth Score _____ <input type="checkbox"/> Other _____
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C. OPINION Having completed A & B as applicable, in your opinion, does patient have a condition that may affect driving:

NO YES May in future - recommend follow-up in _____ years

D. DETAILS OF CONDITION(S) THAT AFFECT OR MAY AFFECT DRIVING May include relevant specialists' reports or lab results.

E. RECOMMENDATION(S)

Specialist Consult - Type _____
 Enclosed: Yes No I will arrange: Yes No
 Road test to assess _____
 Restrictions (Reason & Type) _____

F. DRIVER'S CERTIFICATION AND CONSENT TO RELEASE INFORMATION

- I certify that the information I have given to the Physician or Nurse Practitioner completing this report is to the best of my knowledge true and complete.
- I understand that inaccurate, misleading, missing or false information may lead to denial or cancellation of my driver's licence.
- I authorize the release of this medical report and all past or future reports pertaining to diseases, disabilities and conditions that may affect driving to the Superintendent of Motor Vehicles.

Patient's Signature	Date
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G. RELATIONSHIP WITH PATIENT

- Family physician or NP for _____ years
 Locum Walk-in First Visit NP Specialist

EXAMINING PHYSICIAN'S OR NP'S NAME AND ADDRESS <small>(Print Name or use rubber stamp)</small> TELEPHONE NO. _____	Examination Date _____ Physician's or NP's Signature _____
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INSTRUCTIONS

NOTE TO DRIVER AND PHYSICIAN or NURSE PRACTITIONER (NP): The fee for completing this form is not covered by the Medical Services Plan or by the Superintendent of Motor Vehicles.

To the driver:

- Under section 25 or 29 of the *Motor Vehicle Act* the Superintendent of Motor Vehicles requires you to have this form completed for one of the following reasons: because you have reached an age when medical conditions that affect driving are more common, or because you hold, or have applied for a class 1, 2, 3 or 4 driver's licence, or airbrake endorsement. Refer to the **"REASON FOR EXAMINATION AND CLASS"** on the front of the form.
- This form must be completed and returned by your physician or NP to the Superintendent of Motor Vehicles within 45 days. If medical approval is required prior to obtaining a licence for any class, you will be unable to obtain that licence until the completed form is submitted and approved. If this medical examination is required for a class of licence you already have, your driver's licence may be cancelled if you fail to have the form completed and submitted by your physician or NP within 45 days. This means you will be unable to drive until the form is submitted and you are issued a new driver's licence.
- RoadSafetyBC has no authority to set the fee physicians or nurse practitioners charge, they are entitled to set their own fees and to bill patients directly.
- If you are currently prohibited from driving, this medical report must be completed and returned by your physician or NP before your driving privilege can be considered for reinstatement.
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- Provide details of any medical conditions and medications that may affect driving in part D.
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