

# Driver Medical Fitness Program Overview

RoadSafetyBC



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## Purpose of this Overview

1. To increase health professionals' awareness of Driver Medical Fitness assessment requirements
2. To improve efficiencies in submission of medical information for both RoadSafetyBC and medical practitioners
3. To improve reporting of medically at-risk drivers

## RoadSafetyBC

- RoadSafetyBC – previously the Office of the Superintendent of Motor Vehicles (OSMV) – is the lead Provincial agency responsible for road safety in BC, and is part of the Ministry of Public Safety and Solicitor General.
- The Superintendent of Motor Vehicles is the head of RoadSafetyBC.
- RoadSafetyBC has several programs to accomplish its road safety mandate, including Driver Medical Fitness.

## Driver Medical Fitness Helpful Links

(all hyper-links are accessible in slideshow mode only)

- [Driver Medical Fitness Professionals Page](#)
- [Report of a condition affecting fitness and ability to drive](#)
- [CCMTA Medical Standards with B.C. Specific Guidelines \(BC Guide\)](#)
- Dedicated phone line for physicians and other health professionals (250) 953-8612
- [Enhanced Road Assessment](#)
- [ICBC](#)

## Driver Medical Fitness Program

- The Driver Medical Fitness Program team adjudicates information to determine fitness to drive using:
  - [CCMTA medical Standards for Driving with BC Specific Guidelines](#)
  - Administrative fairness principles and case law
  - **Evidence** of public safety risk and current medical information
- Information received is triaged according to risk

## Driver Medical Fitness Statistics



**3.2  
million  
drivers**

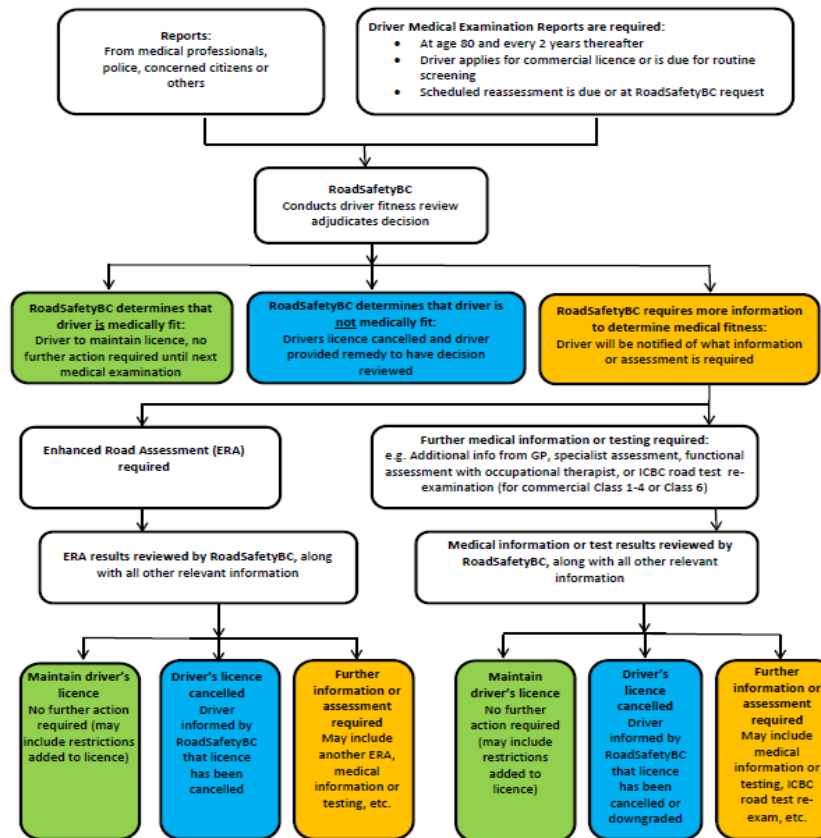
Approximate Annual Volumes:

- 150,000 medical assessments each year
  - 11,000 unsolicited reports
  - 4,000 drivers found unfit
  - 2,000 drivers do not comply and their Driver Licence is cancelled
  - 800 drivers voluntarily surrender their Driver Licence

# Understanding Driver Medical Fitness

Right click on the flow chart to download a printable copy.

## driver medical fitness understanding the driver examination process



\*Anytime RoadSafetyBC cancels a drivers licence, the individual is advised in writing why the cancellation has occurred and what information is required to have the decision reviewed.




## When does a driver get a Driver Medical Examination Report (DMER)?

- RoadSafetyBC receives an unsolicited report of concern from a police, family member or public
- RoadSafetyBC receives an unsolicited report of concern from a medical professional
- Driver discloses a medical condition to a Licensing Office
- A scheduled reassessment interval is due
- A driver turns 80, and every two years thereafter
- A driver applies for a commercial class licence, or a routine commercial class screening is due

[Link to DMER](#)

## Driver Medical Examination Reports (DMER)



RoadSafetyBC  
**DRIVER'S MEDICAL EXAMINATION**  
Doctors may bill STS for this examination through the Teleplan billing system

1

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. 20 of the Access to Information Act for the purpose of administering your fitness to drive a motor vehicle and to allow your medical practitioner to bill the Motor Vehicle Plan for the service. You have no control over the collection of your personal information other than the control information on the "To Whom" section of this form.

AREA ABOVE FOR OFFICE USE

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DRIVER AND PHYSICIAN OR NURSE PRACTITIONER - SEE BACK FOR INSTRUCTIONS

PERSONAL HEALTH NUMBER: \_\_\_\_\_ MSP Fee Code 96220 REASON FOR EXAMINATION AND CLASS: \_\_\_\_\_

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)

<p><b>VISION (section 2 of Physician's Guide)</b></p> <p><input type="checkbox"/> Acuity less than _____  <input type="checkbox"/> Field defect  <input type="checkbox"/> Eye disease  <input type="checkbox"/> Other _____</p> <p><b>HEARING (section 3)</b></p> <p><input type="checkbox"/> Hearing loss  <input type="checkbox"/> Hearing <input type="checkbox"/> with hearing <input type="checkbox"/> without hearing  <input type="checkbox"/> Use of last vestige option  <input type="checkbox"/> Other _____</p> <p><b>MEGALOCHEILIA (section 11)</b></p> <p><input type="checkbox"/> Angiodontia  <input type="checkbox"/> WED Fracture <input type="checkbox"/> Without Fracture  <input type="checkbox"/> Alveolar disease  <input type="checkbox"/> Rootosis  <input type="checkbox"/> Range of motion loss  <input type="checkbox"/> Other _____</p>	<p><b>CARDIOVASCULAR (sections 4 and 6)</b></p> <p><input type="checkbox"/> Group 1a  <input type="checkbox"/> Class  <input type="checkbox"/> DM (N1, asymptotic, DMG, DM, etc.)  <input type="checkbox"/> DM (N2)  <input type="checkbox"/> Hypertension (see)  <input type="checkbox"/> Arrhythmia  <input type="checkbox"/> Aortic disease  <input type="checkbox"/> ED (Primary <input type="checkbox"/> Secondary Date)  <input type="checkbox"/> Congestive heart failure (CHF)  <input type="checkbox"/> Aortic aneurysm Date  <input type="checkbox"/> Aortic dissection Date  <input type="checkbox"/> Other _____</p> <p><b>PSYCHIATRIC (section 12)</b></p> <p><input type="checkbox"/> Depression  <input type="checkbox"/> Anxiety disorder  <input type="checkbox"/> Impaired judgment, insight  <input type="checkbox"/> Medication non-compliance  <input type="checkbox"/> Stable Psych condition  <input type="checkbox"/> Other _____</p>	<p><b>DM (sections 3 and 7)</b></p> <p><input type="checkbox"/> DMG Type _____  <input type="checkbox"/> Insulin dependent <input type="checkbox"/> Prevalent <input type="checkbox"/> History  <input type="checkbox"/> Stable last option  <input type="checkbox"/> Hypertension  <input type="checkbox"/> Congestive heart failure (CHF) (see, etc.)  <input type="checkbox"/> Aortic disease  <input type="checkbox"/> ED (Primary <input type="checkbox"/> Secondary Date)  <input type="checkbox"/> Congestive heart failure (CHF)  <input type="checkbox"/> Aortic aneurysm Date  <input type="checkbox"/> Aortic dissection Date  <input type="checkbox"/> Other _____</p> <p><b>URINARY (section 8)</b></p> <p><input type="checkbox"/> Diabetes Insulin <input type="checkbox"/> No <input type="checkbox"/> No  <input type="checkbox"/> Stable hypoglycemia Date  <input type="checkbox"/> Hypoglycemia/awareness Date  <input type="checkbox"/> Stable last option  <input type="checkbox"/> Other _____</p> <p><b>DRUGS AND ALCOHOL (sections 13 and 14)</b></p> <p><input type="checkbox"/> Dependent  <input type="checkbox"/> Abuse of drug/alcohol in past 7 years  <input type="checkbox"/> Alcohol related issues  <input type="checkbox"/> Abuse of other substances  <input type="checkbox"/> Medication non-compliance  <input type="checkbox"/> Hypnotic drugs  <input type="checkbox"/> Narcotics  <input type="checkbox"/> Other _____</p> <p><b>OTHER CONDITIONS</b></p> <p><input type="checkbox"/> General quality or functional decline  <input type="checkbox"/> Other (see guide)</p>	<p><b>RESPIRATORY (section 9)</b></p> <p><input type="checkbox"/> Stable respiratory disease  <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Mild <input type="checkbox"/> Moderate  <input type="checkbox"/> COPD  <input type="checkbox"/> Asthma  <input type="checkbox"/> Sleep apnea  <input type="checkbox"/> Other _____</p> <p><b>LABORATORY (section 10)</b></p> <p><input type="checkbox"/> Hemoglobin  <input type="checkbox"/> Hematocrit  <input type="checkbox"/> Hemoglobin A1c  <input type="checkbox"/> Other _____</p> <p><b>NEUROLOGICAL (section 11)</b></p> <p><input type="checkbox"/> Epilepsy  <input type="checkbox"/> Stroke  <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> Alzheimer's Disease  <input type="checkbox"/> Parkinson's Disease  <input type="checkbox"/> Huntington's Disease  <input type="checkbox"/> Other _____</p> <p><b>PSYCHIATRIC (section 12)</b></p> <p><input type="checkbox"/> Depression  <input type="checkbox"/> Anxiety disorder  <input type="checkbox"/> Impaired judgment, insight  <input type="checkbox"/> Medication non-compliance  <input type="checkbox"/> Stable Psych condition  <input type="checkbox"/> Other _____</p>
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B. VISION SCREENING AND PHYSICAL FINDINGS AFFECTING DRIVING May include EVFVFT done within one year if available.

<p><b>VISION ACUITY</b></p> <p><input type="checkbox"/> Uncorrected R _____ with _____  <input type="checkbox"/> Corrected R _____ with _____</p>	<p><b>VISION FIELD</b></p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Sub must occur and must last meet Physician's Guide criteria for license class <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Best Pressure</p>
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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

F. DRIVER'S CERTIFICATION AND CONSENT TO RELEASE INFORMATION

1. 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.  
 2. I understand that inaccurate, misleading, missing or false information may lead to denial or cancellation of my driver's license.  
 3. I authorize the release of this medical report and all past or future reports pertaining to diagnosis, disabilities and conditions that may affect driving to the Superintendent of Motor Vehicles.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

G. RELATIONSHIP WITH PATIENT

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


EXAMINER PHYSICIAN OR NP'S NAME AND ADDRESS (Print name or on letter copy) \_\_\_\_\_ Examination Date: \_\_\_\_\_

Physician or NP's Signature: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_

PHYSICIAN OR NP: FAX TO 250-952-8888 OR MAIL TO RoadSafetyBC, P.O. BOX 9254, STN PROV GOVT, VICTORIA, BC, V8W 9L2  
MS2011D (1/19)



RoadSafetyBC  
**DRIVER'S MEDICAL EXAMINATION**  
Doctors may bill STS for this examination through the Teleplan billing system

2

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. 20 of the Access to Information Act for the purpose of administering your fitness to drive a motor vehicle. You have no control over the collection of your personal information other than the control information on the "To Whom" section of this form.

AREA ABOVE FOR OFFICE USE

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DRIVER AND PHYSICIAN OR NURSE PRACTITIONER - SEE BACK FOR INSTRUCTIONS

PERSONAL HEALTH NUMBER: \_\_\_\_\_ MSP Fee Code 96220 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)

<p><b>VISION (section 2 of Physician's Guide)</b></p> <p><input type="checkbox"/> Acuity less than _____  <input type="checkbox"/> Field defect  <input type="checkbox"/> Eye disease  <input type="checkbox"/> Other _____</p> <p><b>HEARING (section 3)</b></p> <p><input type="checkbox"/> Hearing loss  <input type="checkbox"/> Hearing <input type="checkbox"/> with hearing <input type="checkbox"/> without hearing  <input type="checkbox"/> Use of last vestige option  <input type="checkbox"/> Other _____</p> <p><b>MEGALOCHEILIA (section 11)</b></p> <p><input type="checkbox"/> Angiodontia  <input type="checkbox"/> WED Fracture <input type="checkbox"/> Without Fracture  <input type="checkbox"/> Alveolar disease  <input type="checkbox"/> Rootosis  <input type="checkbox"/> Range of motion loss  <input type="checkbox"/> Other _____</p>	<p><b>CARDIOVASCULAR (sections 4 and 6)</b></p> <p><input type="checkbox"/> Group 1a  <input type="checkbox"/> Class  <input type="checkbox"/> DM (N1, asymptotic, 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CONDITIONS</b></p> <p><input type="checkbox"/> General quality or functional decline  <input type="checkbox"/> Other (see guide)</p>
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B. VISION SCREENING AND PHYSICAL FINDINGS AFFECTING DRIVING May include EVFVFT done within one year if available.

<p><b>VISION ACUITY</b></p> <p><input type="checkbox"/> Uncorrected R _____ with _____  <input type="checkbox"/> Corrected R _____ with _____</p>	<p><b>VISION FIELD</b></p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Sub must occur and must last meet Physician's Guide criteria for license class <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Best Pressure</p>
---	---

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

F. DRIVER'S CERTIFICATION AND CONSENT TO RELEASE INFORMATION

1. 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.  
 2. I understand that inaccurate, misleading, missing or false information may lead to denial or cancellation of my driver's license.  
 3. I authorize the release of this medical report and all past or future reports pertaining to diagnosis, disabilities and conditions that may affect driving to the Superintendent of Motor Vehicles.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

G. RELATIONSHIP WITH PATIENT

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

EXAMINER PHYSICIAN OR NP'S NAME AND ADDRESS (Print name or on letter copy) \_\_\_\_\_ Examination Date: \_\_\_\_\_

Physician or NP's Signature: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_

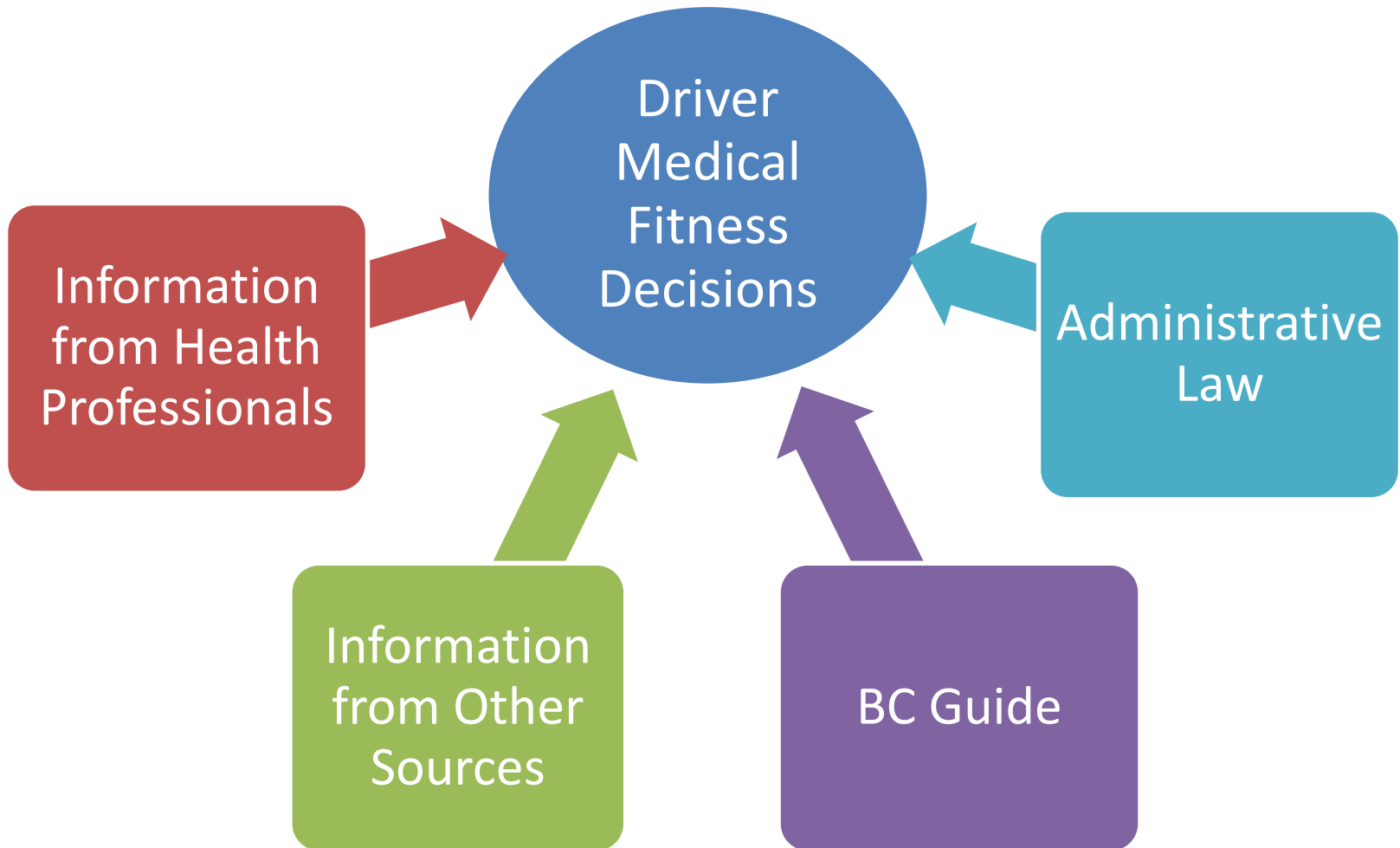
PHYSICIAN OR NP: FAX TO 250-952-8888 OR MAIL TO RoadSafetyBC, P.O. BOX 9254, STN PROV GOVT, VICTORIA, BC, V8W 9L2  
MS2011D (1/19)

Known or Suspected Medical Condition

Age Related or Commercial Reassessment

10

## Driver Medical Fitness Decisions



Information  
from Health  
Professionals

To meet the obligations of administrative fairness and case law, Health Professional assessments should include:

- Diagnosis (alone does not suffice)
- Associated symptoms, co-morbidities
- Level of severity, stability, acute/chronic
- Treatment compliance
- Collateral information (assessments, tests, specialist reports, reports from family, police reports)

Information from Health Professionals

# Example: Reporting Cognitive Function

## Should include:

- A cognitive test score
- Associated clinical attributes and history
- Education level, learning disability
- Language barriers
- Family concerns

<b>A. HISTORY</b> (Reference to the 2010 BC Guide to Drive In Determining Fitness to Drive: Web links are provided on the back of form)			
<b>VISION</b> (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 _____	<b>CARDIOVASCULAR</b> (sections 4 and 6) <input type="checkbox"/> Syncope Date _____ Cause _____ <input type="checkbox"/> CAD (M.I., angioplasty, CABG) Date _____ NYHA Functional Class _____ <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Pacemaker <input type="checkbox"/> ICD <input type="checkbox"/> Primary <input type="checkbox"/> Secondary Date _____ <input type="checkbox"/> Congestive heart failure: LVEF _____ <input type="checkbox"/> Aneurysm Site _____ Size _____ <input type="checkbox"/> Peripheral Vascular disease <input type="checkbox"/> Other _____	<b>CNS</b> (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"/> Cognitive impairment: MOCA _____ MMSE _____ <input type="checkbox"/> Dementia Diagnosis _____ GDS _____ <input type="checkbox"/> Significant head injury <input type="checkbox"/> Other _____	<b>RESPIRATORY</b> (section 8) <input type="checkbox"/> Oxygen required when driving <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe <input type="checkbox"/> CPAP compliant _____ <input type="checkbox"/> Apnea Hypopnea Index (AHI) _____ <input type="checkbox"/> Epworth Score _____
<b>HEARING</b> (section 3) <input type="checkbox"/> Hearing loss <input type="checkbox"/> Vertigo <input type="checkbox"/> with warnings <input type="checkbox"/> without warnings <input type="checkbox"/> Date of last vertigo episode _____ <input type="checkbox"/> Other _____	<b>MUSCULOSKELETAL</b> (section 11) <input type="checkbox"/> Amputation Limb affected _____ Date _____ <input type="checkbox"/> With Prosthesis <input type="checkbox"/> Without Prosthesis <input type="checkbox"/> Adaptive Device _____ <input type="checkbox"/> None <input type="checkbox"/> Weakness <input type="checkbox"/> Range of motion loss <input type="checkbox"/> Other _____	<b>PSYCHIATRIC</b> (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 _____	<b>ENDOCRINE</b> (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 _____
<b>DRUGS AND ALCOHOL</b> (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 _____ refused _____ <input type="checkbox"/> Prescribed drugs that could impair <input type="checkbox"/> Psychoactive drugs <input type="checkbox"/> Narcotics <input type="checkbox"/> Other _____			
<b>B. VISION SCREENING AND PHYSICAL FINDINGS AFFECTING DRIVING</b> May include EVF/VFT done within one year if available.			
<b>VISUAL ACUITY</b> <input type="checkbox"/> Uncorrected R _____ L _____ Both _____ <input type="checkbox"/> Corrected R _____ L _____ Both _____		<b>VISUAL FIELD</b> <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 <input type="checkbox"/> NO Blood Pressure _____	
<b>C. OPINION</b> Having completed A & B as applicable, in your opinion, does patient have a condition that may affect driving: <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> May In future - recommend follow-up in _____ years			
<b>D. DETAILS OF CONDITION(S) THAT AFFECT OR MAY AFFECT DRIVING</b> May include relevant specialists' reports or lab results.			
_____ _____ _____			
<b>E. RECOMMENDATION(S)</b>			
<input type="checkbox"/> Specialist Consult - Type _____ Enclosed: <input type="checkbox"/> Yes <input type="checkbox"/> No I will arrange: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Road test to assess _____ <input type="checkbox"/> Restrictions (Reason & Type) _____	

Information from Health Professionals

Should include:

- Diagnosis
- Specifics (date of event/loss of ability)
- Extent of ROM loss
- Specify which limbs are affected
- Severity
- Progressive, transient, stable

# Example: Reporting Motor & Sensory Function

<input type="checkbox"/> Vertigo <input type="checkbox"/> with warnings <input type="checkbox"/> without warnings <input type="checkbox"/> Date of last vertigo episode _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Congestive heart failure: LVEF _____ <input type="checkbox"/> Aneurysm Site _____ Size _____ <input type="checkbox"/> Peripheral Vascular disease <input type="checkbox"/> Other _____	<input type="checkbox"/> Cognitive impairment MOCA _____ MMSE _____ <input type="checkbox"/> Dementia Diagnosis _____ GDS _____ <input type="checkbox"/> Significant head injury <input type="checkbox"/> Other _____	<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 <input type="checkbox"/> HbA1 C _____ Date _____ <input type="checkbox"/> Other _____
<b>MUSCULOSKELETAL (section 11)</b> <input type="checkbox"/> Amputation Limb affected _____ Date _____ <input type="checkbox"/> With Prosthesis <input type="checkbox"/> Without Prosthesis <input type="checkbox"/> Adaptive Device _____ <input type="checkbox"/> None <input type="checkbox"/> Weakness <input type="checkbox"/> Range of motion loss <input type="checkbox"/> Other _____	<b>PSYCHIATRIC (section 12)</b> <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 _____	<b>DRUGS AND ALCOHOL (sections 13 and 14)</b> <input type="checkbox"/> Alcohol or drug abuse in past 2 years <input type="checkbox"/> Alcohol related seizure <input type="checkbox"/> Addiction rehab taken _____ refused _____ <input type="checkbox"/> Prescribed drugs that could impair <input type="checkbox"/> Psychoactive drugs <input type="checkbox"/> Narcotics <input type="checkbox"/> Other _____	<b>OTHER CONDITIONS</b> <input type="checkbox"/> General debility or functional decline <input type="checkbox"/> Other (see guide) _____
<b>B. VISION SCREENING AND PHYSICAL FINDINGS AFFECTING DRIVING</b> May include EVF/VFT done within one year if available.			
<b>VISUAL ACUITY</b> <input type="checkbox"/> Uncorrected R _____ L _____ Both _____ <input type="checkbox"/> Corrected R _____ L _____ Both _____		<b>VISUAL FIELD</b> <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 _____	
<b>C. OPINION</b> Having completed A & B as applicable, in your opinion, does patient have a condition that may affect driving:			
<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> May in future - recommend follow-up in _____ years			
<b>D. DETAILS OF CONDITION(S) THAT AFFECT OR MAY AFFECT DRIVING</b> May include relevant specialists' reports or lab results.			
_____ _____ _____			
<b>E. RECOMMENDATION(S)</b>			
<input type="checkbox"/> Specialist Consult - Type _____ Enclosed: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Road test to assess _____ <input type="checkbox"/> Restrictions (Reason & Type) _____	
I will arrange: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Information  
from Other  
Sources

## Unsolicited Reporting

- 11,000 reports sent in by medical personnel, police, family, and ICBC with concerns regarding the safety or fitness of a person to drive.
- The following conditions are of particular concern to road safety: declining cognitive abilities, seizures, psychiatric disorders, and problematic alcohol/substance use.

[Members of the Public Reporting a Concern about a Person's Fitness to Drive](#)

BC Guide

## Upon review of Evidence Received

Driver Medical Fitness Adjudicators may:

- Request further medical information
- Request a Functional Driving Evaluation:
  - [Enhanced Road Assessment \(ERA\)](#)
  - [ICBC Road Test re-examination](#)
  - Occupational Therapist/Specialist Driving Evaluation
- Cancel a driver's licence/downgrade
- Find the driver medically fit to drive



Administrative  
Law

## Administrative Law Considerations

- The Superintendent has ultimate responsibility under the *Motor Vehicle Act* for determining a person's fitness to drive.
- The test to be met for Driver Medical Fitness decisions is reasonableness.

Administrative  
Law

## Administrative Law Principles are applied in Driver Medical Fitness Determinations

A person affected by a statutory decision has the right to know the case against them and must be given an opportunity to respond to it.

The four basic principles of administrative law:

- The person has a right to notice of a decision that will affect them.
- The person has a right to make a response to that decision.
- The person has a right to have the decision made by an impartial and independent decision maker.
- The person has a right to know the reasons for the decision.

A reasonable decision is one which falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

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## Cancellation of a Licence

If a Driver Medical Fitness decision is to cancel a licence it must be based on:

- Reasonably reliable evidence of medical issue
- Reasonably reliable evidence of road safety risk

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## Urgent Cancellation

To urgently cancel a driver's licence, the information must meet the following:

1. Evidence of medical urgency
2. High threshold of public safety and immediate road safety concerns
3. Timeliness: date of the event/episode must be current (within 30 - 60 days, condition specific)

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## Urgent Cancellation

IF the evidence meets the three criteria, then:

- The licence is cancelled immediately and the driver is sent a cancellation notice and letter via mail
- The driver is given 21 days to request reconsideration of the decision to urgently cancel their licence
- A remedy is provided in the letter (the information RoadSafetyBC will need to consider re-licensing)

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## Notice to Cancel

- When all three urgent cancellation criteria are not met, a Notice to Cancel (NTC) is issued
- In NTC cases, the driver is notified in writing that RoadSafetyBC's preliminary assessment is that the driver's licence should be cancelled
- The driver has 30 days to respond to the concerns raised before a final decision is made

## Enforcement Options

If you are aware that a driver is continuing to drive after their licence has been cancelled, you may:

- Complete the [Report of a condition affecting fitness and ability to drive](#) form or write a letter to RoadSafetyBC and fax to 250-952-6888
- Phone RoadSafetyBC at 250-953-8612 and speak to a Nurse Case Manager who can assist you with reporting
- Phone your local police or RCMP to report your concerns

RoadsafetyBC can then take steps to prohibit the driver.

## Enforcement Options

If police encounter an unlicensed driver they may:

- Issue a violation ticket for the offense of no valid driver's licence, or warn the driver

If a driver is convicted of a no driver licence infraction:

- ICBC records will post driver as "Vehicle Impoundment candidate/serve prohibition". Police may then:
  - Issue a violation ticket to the driver again and police must:
    - give an Unlicensed Driver prohibition (driver is prohibited indefinitely)
    - impound vehicle for 7 days (time increases with subsequent violations)



## Enforcement Options

If a prohibited driver is stopped by police:

- Driver can be charged and is subject to arrest
- Driver can be issued with a Provincial Appearance Notice resulting in a mandatory court appearance
- Vehicle must be impounded for 7 days
- Documents and report will be submitted to Crown for approval
- If convicted in court – minimum penalty is \$500 with a mandatory 12 month automatic driving prohibition

# Thank you

If you would like to provide feedback on this presentation, please send your comments or questions to:

[RoadSafetyBC@gov.bc.ca](mailto:RoadSafetyBC@gov.bc.ca)