# STATEMENT OF PHYSICIAN

NEBRASKA DEPARTMENT OF MOTOR VEHICLES
Once completed, please mail or fax to: PO Box 94726 Lincoln, NE 68509
FAX: 402-471-4020

**NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE**

(Applicant completes before exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my physical and psychological condition or history to the Department of Motor Vehicles, State of Nebraska.

Dated: _____ Signed: _____
(Applicant's Signature)

I hereby certify that I examined _____
(Applicant's Name)

of _____
(Street Address) (City) (Zip Code)

Date of Birth _____ License Number _____

To be completed by physician.

## NEUROLOGICAL AND NEUROMUSCULAR DISEASES/CONDITION/INJURY:

**I. CONDITION CAUSING CONFUSION, MEMORY LOSS OR LOSS OF CONSCIOUSNESS (Check)**

1. ☐ Epilepsy-Type: _____ ☐ Narcolepsy
   ☐ Alcoholism *(complete Alcohol section below)* ☐ Cerebral Vascular Disease ☐ Other: _____
2. Frequency of seizures: _____ Date of last seizure: _____
   Reason for seizure _____
3. Frequency of loss of consciousness: _____ Date of last occurrence of loss of consciousness: _____
   Reason for loss of consciousness _____
4. Current medication and dosage: _____
   Have significant sedative or hypnotic effects occurred: ☐No ☐Yes ☐ Explain _____
5. Is this condition likely to worsen in the near future affecting the person's ability to operate a motor vehicle? ☐ No ☐ Yes
   Explain: _____

**II. OTHER LIMITING OR PROGRESSIVE NEUROLOGIC OR NEUROMUSCULAR DISEASES (CEREBRAL PALSY, PARAPLEGIA, MUSCULAR DYSTROPHY, PARKINSONISM, STROKE, MULTIPLE SCLEROSIS, ETC.)**

1. Specific diagnosis: _____ Age at onset: _____
2. Significant deterioration of neuromuscular function (strength, coordination) in the past year? _____
3. Describe the patient's neuromuscular functional limitations (strength, coordination, etc.): _____

## CONDITION CAUSING VERTIGO OR MULTIPLE EPISODES OF DIZZINESS OR FAINTING:

1. Specific diagnosis: _____ Date of last occurrence: _____
2. Has condition been resolved? _____ Please explain: _____

## DRUGS AND ALCOHOL EVALUATION:

1. Does the patient have or is there any objective evidence of addiction or habituation to drugs, tranquilizers or alcohol?
   ☐ No ☐ Yes If yes, type of drug and duration _____
2. Is patient currently under therapy? ☐ No ☐ Yes Explain: _____
3. Evidence of physical complications of alcohol or drugs (please state): _____

## PSYCHOLOGICAL EVALUATION:

1. Diagnosis of psychiatric illness: _____

If any of the following symptoms are present please mark #1 or a #2

1. Does not impair ability to operate a motor vehicle. 2. Impairs ability to operate a motor vehicle.

| | | |
|---|---|---|
| ( ) Anxiety | ( ) Visual or auditory | ( ) Impairment of judgment |
| ( ) Delusions | ( ) Suicidal impulses or behavior | ( ) Impairment of memory |
| ( ) Euphoria | ( ) Homicidal impulses or behavior | ( ) Daytime sleepiness |
| ( ) Hallucinations | ( ) Paranoid ideation | ( ) Other: _____ |
| ( ) Intermittent Explosive Episodes | ( ) Depression | |

To be completed by physician.

## MEDICAL EVALUATION:

### I. DIABETES

Type: ☐ Adult Onset ☐ Juvenile Onset Duration: _____

Insulin: ☐ No ☐ Yes Dose: _____

Oral hypoglycemic agents..... ☐ No ☐ Yes Dose: _____

Hypoglycemic reactions ..... ☐ No ☐ Yes Frequency: _____

Date of last reaction: _____

Renal Disease..... ☐ No ☐ Yes BUN _____ Creatinine _____

Retinopathy..... ☐ No ☐ Yes

Should statement on vision be required?.. ☐ No ☐ Yes

### II. ARTERIOSCLEROSIS

Peripheral vascular disease..... ☐ No ☐ Yes *

Cerebral vascular disease..... ☐ No ☐ Yes * *If yes, please complete Section III, HEART DISEASE.

Coronary vascular disease..... ☐ No ☐ Yes *

### III. HEART DISEASE

Diagnosis: _____

Angina: ☐ No ☐ Yes Frequency: _____ Date of Onset: _____ During Driving: ☐ No ☐ Yes

Lightheadedness: ☐ No ☐ Yes Syncope: ☐ No ☐ Yes

Arrhythmia: ☐ No ☐ Yes Type: _____ Frequency: _____

Infarction: ☐ No ☐ Yes Number and dates: _____

Congestive failure at present: ☐ No ☐ Yes Ever: ☐ No ☐ Yes

Pacemaker: ☐ No ☐ Yes

Blood Pressure: _____ Heart Rate: _____

## GENERAL STATEMENTS (THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY):

1 In your professional opinion, is this patient mentally capable of operating a motor vehicle safely?
☐ No ☐ Yes ☐ Only if appropriate tests as determined by the DMV are passed .

2. In your professional opinion, is this patient physically capable of operating a motor vehicle safely?
☐ No ☐ Yes ☐ Only if appropriate tests as determined by the DMV are passed .

3. Do you feel that this patient should have a medical evaluation for the purpose of operating a motor vehicle safely?
☐ No ☐ Yes ☐ If yes, how often? _____

If you wish to make additional comments, such as driving distance or day or night driving, or you have any recommended restrictions patient should have on license, please use space below or additional sheet(s) as necessary.

_____

If there are any other medical conditions not shown on this report that would affect the patient's ability to safely operate a motor vehicle, please describe as to frequency, severity, etc.:

_____

4. Based upon your examination, has the medical condition of this patient significantly worsened or another condition developed?
☐ No ☐ Yes If yes, please explain including how this affects the person's ability to safely operate a motor vehicle. _____

_____

**For Commercial Motor Vehicle Operators Only:** Was this condition in existence prior to July 30, 1996? ☐ No ☐ Yes

**DATE OF EXAMINATION:** _____ **(MUST BE COMPLETED—STATEMENT OF PHYSICIAN NOT VALID 90 DAYS FROM EXAMINATION DATE.)**

Name (Print or Type) _____ M.D. or D.O.

Type of Practice _____ Signature _____

Address _____

Phone Number: _____ Fax Number: _____



*TSIE5 07/12*
*DMV0-191*

# CITIZEN REEXAMINATION REPORT

**Director**
**Department of Motor Vehicles**
**Driver Licensing Division**
**PO Box 94726**
**Lincoln, NE 68509-4726**

Dear Director:

As provided for in Nebraska Statute 60-4,118, I request that _____ (Name)

Of _____ (Address), Nebraska

and date of birth _____ be recalled for examination for, in my opinion, he or she is not capable of operating a motor vehicle safely over the highways of the State of Nebraska for the following reasons: *(Please give a **detailed explanation** of the reasons for reexamination. ie. Examples of poor driving behavior that you have personally witnessed or that have been reported to you by a reliable source, and/or known medical conditions that could affect safe driving.)*

_____

_____

_____

_____

_____

_____

_____

_____

**(All information on this report must be completed in order for it to be accepted)**

*I authorize the release of all information related to the citizen reexamination report* ☐ *Yes* ☐ *No*

_____ _____
*Signature of Person Requesting Reexamination* *Printed Name.*

_____
*Relationship to Driver*

_____ _____
*Address* *Daytime Phone Number*

*****A copy of the requestor's driver's license must be enclosed with this report.***

**FOR OFFICE USE ONLY:**

DMV06-12A-09/12

NEBRASKA DEPARTMENT OF MOTOR VEHICLES

# STATEMENT OF VISION

Once completed, please mail or fax to: P.O. Box 94726 Lincoln, NE 68509

FAX: 402-471-4020

**NOT VALID AFTER 90 DAYSFROM EXAMINATION DATE**

(Applicant completes before doctor's exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my visual condition and history to the Department of Motor Vehicles, State of Nebraska.

Dated: _____ Signed: _____
*(Applicant's Signature)*

I hereby certify that I examined the eyes of _____
*(Applicant's Name)*

of _____
*(Street Address)* *(City)* *(Zip Code)*

Date of Birth _____ License Number _____

**To be completed by optometrist or ophthalmologist. (REQUIRED)**

1. Unaided acuity: Both _____ Left Eye _____ Right Eye_____

2. a. Best correctable acuity: Both _____ Left Eye _____Right Eye _____

   b. Visual acuity using telescopic lens: 20/_____ Both 20/_____ Left 20/_____ Right

   c. Visual acuity through carrier lens: 20/_____ Both 20/_____ Left 20/_____ Right

   d. Type of lenses used: Std. Spectacle _____ Aphakic _____
   Contact Lenses _____ Telescopic Lenses _____

3. Extent of entire horizontal form field, either binocular or monocular, as determined with a III4e or V4e Goldmann test target or equivalent, such as the SSA Kinetic V4e isopter test on Humphrey Field Analyzers.

   Left Eye: _____ Degrees Temporal Right Eye: _____ Degrees Temporal
   _____ Degrees Nasal _____ Degrees Nasal

   Field of Vision looking through carrier lens: _____° Temp Left _____° Temp Right
   _____° Nasal Left _____° Nasal Right

To be completed by optometrist or ophthalmologist. (REQUIRED)

4. Are new corrective lenses required? Yes _____ No _____

5. Diplopia: *(Check appropriate line.)*

   _____ a. highly unlikely to occur

   _____ b. intermittent* *Please Explain:_____

   _____ c. constant* _____

6. If best visual acuity is less than 20/40 in either eye or both, or total horizontal form field is less than 140 degrees, give cause and probable prognosis under Additional Comments.

**Answer questions #7 and #8 only for commercial motor vehicle operators.**

7. Based upon your examination, has the vision condition of this patient, which was in existence prior to July 30, 1996, significantly worsened or another condition developed? ☐ No ☐ Yes

   If yes, please explain: _____

   _____

8. Color blindness: Able to recognize the colors of traffic signals and devices showing standard red, green and amber. ☐ No ☐ Yes

9. In my opinion, this applicant should have their vision retested for driving purposes in ____ years.

10. **Date of eye examination:** _____

**(MUST BE COMPLETED—STATEMENT OF VISION NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE.)**

Additional Comments: _____

_____

_____

_____

_____

_____ _____

Name of Optometrist or Ophthalmologist (Please Print)

Signature of Optometrist or Ophthalmologist*

_____

Address of Optometrist or Ophthalmologist (Please Print)

Telephone Number of Optometrist or Ophthalmologist: (____) _____

Fax Number of Optometrist or Ophthalmologist: (____) _____

*** If the applicant needs new corrective lenses to get the best correctable acuities listed on page 1, please delay signing this statement until the new lenses are in use by the applicant.**



*TSIE7 07/12*
*DMV06-181*