Government of **Western Australia**
Department of **Transport**

M107A

Medical Assessment Certificate
Fitness to Drive

Please read the detailed medical assessment instructions (M106A) for the applicant and health professional. This form may be submitted to the Department of Transport (DoT) via email to dss@transport.wa.gov.au, via Electronic Medical Assessment (enquire with your GP), or post to the Occupational Health Physician, C/O Department of Transport, GPO Box R1290, PERTH WA 6844. Please mark as Confidential.

Applicant details - to be completed by applicant or Department of Transport

FAMILY NAME	
GIVEN NAMES	DATE OF BIRTH
RESIDENTIAL ADDRESS	

I consent to any reporting health professional releasing information to DoT and DoT contacting any health professional to obtain further information which is relevant to my fitness to drive. I certify that all information within this form is true and correct.

SIGNATURE

Please indicate the authorisations/extensions you are proposing to drive and/or retain. Any authorisations/extensions not indicated will be surrendered. If you surrender an authorisation/ extension and wish to obtain it again in the future, you will be required to make an application, complete the required assessments and pay the associated fees

STANDARD	PRIVATE			COMMERCIAL						
TYPE OF VEHICLE	MOTOR CAR	MOTORCYCLE	LIGHT RIGID	MEDIUM RIGID	HEAVY RIGID	HEAVY COMBINATION	MULTI COMBINATION	DRIVER INSTRUCTORS	TAXI	CARRY PASSENGERS FOR REWARD
CLASS	☐ C	☐ R	☐ LR	☐ MR	☐ HR	☐ HC	☐ MC	☐ DI	☐ T EXTENSION	☐ F EXTENSION

CLASS/ES OF VEHICLE CURRENTLY AUTHORISED TO DRIVE:
EXTENSION/S HELD:
APPLIED FOR AUTHORISATION TO DRIVE VEHICLES OF CLASS/ES:
EXTENSION/S APPLIED FOR

☐ Licence/extension application

☐ Current licence

REASON FOR REFERRAL

DRIVER'S LICENCE / PERMIT NO:	EXPIRY DATE:
APPLICATION TYPE:	
APPLICANT SUFFERS FROM: **APPLICANT IS UNDER THE FOLLOWING TREATMENT/MEDICATION:**	

The Department of Transport has reason to believe that the following background information may be of some assistance:

DOT#21 28.05.2018

Enquiries 13 11 56

Assessment of Fitness to Drive (AFTD) - to be completed by health professional

Please answer all questions below:

1. Were you familiar with the patient's medical history prior to this examination? ☐ Yes ☐ No

2. I have attended this patient professionally since: _____ (Month/Year)

Visual Acuity:

☐ Uncorrected			☐ Corrected		
R	L	B	R	L	B
6/	6/	6/	6/	6/	6/

Blood Pressure Reading _____

Relevant AFTD Medical Condition/s _____

3. Clinical Findings
Please provide where applicable

- details of AFTD medical condition/s
- treatments
- history of episodes
- details of control or complication/s
- conditions of licence
- results of relevant investigations e.g. Hba1c for diabetes

_____

4. In my opinion the person who is the subject of this report:

a. ☐ **Meets the relevant medical criteria -** Fit to drive

b. ☐ **Does not meet the relevant medical criteria -** Not fit to drive
Criteria not met - (Please detail relevant clinical findings at question 3)

c. ☐ **Is suitable to drive subject to conditions -** Fit to drive with conditions
(Please enter relevant clinical findings at question 3)
Note: A conditional licence will not be issued unless adequate supporting information is provided by the examining health professional to the relevant department.

5. Requires specialist assessment ☐ Yes ☐ No Please specify _____

☐ **Occupational Therapist assessment (may include driving assessment)**

☐ **On-road practical driving assessment by the Department of Transport**
By selecting this option you are confirming that the patient is fit to undertake an on-road practical driving assessment with a DoT driving assessor.

6. Recommended re-assessment period ☐☐ years

7. I have discussed this recommendation with patient ☐ Yes ☐ No

8. I have examined the patient according to: ☐ **Commercial vehicle standards** **OR** ☐ **Private vehicle standards** (Heavy vehicle drivers, class MR and above, F extension holders, Taxi drivers, Dangerous goods vehicle driver, Driving Instructors)

DATE OF EXAMINATION	DATE OF REPORT	SURGERY STAMP
REPORTING PROFESSIONAL'S NAME AND QUALIFICATION		

I certify that I have examined the above-mentioned patient in accordance with the relevant National Medical Standards (private or commercial vehicle standards) as set out in ***Assessing Fitness to Drive Guidelines.***

TELEPHONE	FAX	SIGNATURE	☐ FURTHER COMMENTS ON MEDICAL CONDITION(S) AFFECTING SAFE DRIVING ARE ATTACHED
EMAIL ADDRESS			