



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 driver.assessment@transport.wa.gov.au, 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 named on this form releasing information to the Department of Transport (DoT) and DoT contacting any reporting health professional named on this form to obtain any further information relevant to my fitness to drive.

SIGNATURE

Licence details current and proposed. Please circle the class/es of vehicle you are currently authorised to drive or are proposing to drive.

STANDARD	PRIVATE			COMMERCIAL						
	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

DRIVER'S LICENCE / PERMIT NO:	EXPIRY DATE:
APPLICATION TYPE:	
APPLICANT HAS DECLARED THAT:	
HE/SHE SUFFERS FROM	
HE/SHE TAKES AS MEDICATION	

REASON FOR REFERRAL

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

Assessment of Fitness to Drive - 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:

Blood Pressure Reading _____

Other Medical Condition _____

<input type="checkbox"/> Uncorrected			<input type="checkbox"/> Corrected		
R	L	B	R	L	B
6/	6/	6/	6/	6/	6/

3. Clinical Findings

Please provide where applicable

- details of medical condition
- 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

6. Recommended re-assessment period years months

7. I have discussed this recommendation with patient Yes No

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

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	<input type="checkbox"/> FURTHER COMMENTS ON MEDICAL CONDITION(S) AFFECTING SAFE DRIVING ARE ATTACHED
EMAIL ADDRESS			