Driver's Medical Certificate

Transportation and Infrastructure, Highway Safety Division

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PO Box 2000, Charlottetown, PE C1A 7N8
Tel: 902-368-5210
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120 Heather Moyse Drive
Summerside, PE C1N 5L2
Tel: 902-888-8264
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This certificate is to be used to record the results of a medical examination by a physician on behalf of an application for a driver's license issued pursuant to the ***Highway Traffic Act*** and Regulations.

Pursuant to Section 70(6) of the ***Highway Traffic Act***, the Registrar may, before issuing a driver's license, or any time after he has issued the license to the person, require the person to undergo a medical examination and produce a certificate on such form as the Registrar may provide to determine whether the person is physically and mentally competent to operate any class of motor vehicle.

In determining whether or not a person is medically fit to operate a motor vehicle, the Registrar and Highway Safety Medical Review Board shall apply the standards set out in the most recent edition of the Medical Standards for Drivers manual published by the Canadian Council of Motor Transport Administrators.

Important Note: The costs associated with the completion of this report are the responsibility of the driver/patient.

Personal Information on this form is collected under the authority of section 70 of Prince Edward Island's Highway Traffic Act and will be used for the purpose of the issuance of a driver's license to an applicant. If you have any questions about this collection of personal information, you may contact the Department of Transportation and Infrastructure, Registrar of Motor Vehicles, PO Box 2000, Charlottetown, PE C1A 7N8.- Telephone: (902)-368-5223.

PART I – DRIVER/PATIENT INFORMATION - PLEASE COMPLETE

Name _____ Driver's License # _____

Address _____ Date of Birth _____

_____ Telephone: (home) ( ) _____

Postal Code _____ (work) ( ) _____

Reason _____

Issuing Person _____ Date _____

This certificate is submitted in support of my application to obtain or retain the following class of driver's license:

Class 1 ☐ (tractor-trailer)	Class 2 ☐ (bus/school bus)	Class 3 ☐ (straight truck)	Class 4 ☐ (ambulance/bus/taxi)	Class 5 ☐ (passenger car/light truck)
Class 6 ☐ (motorcycle)	English ☐ French ☐	Class 7 ☐ (instruction permit)	Class 8 ☐ (moped)	Class 9 ☐ (farm tractor)

Driver's Release of medical and driving record information to Highway Safety Division and for the Highway Safety Division to report to Physician.

I certify that the foregoing information is, to the best of my knowledge, correct.

_____ _____

Signature of Driver/Patient **Date**

COMMERCIAL VEHICLE DRIVERS

Effective March 31, 1999, Canadian commercial vehicle drivers will no longer be required to carry a medical card for inspection by US officials as proof of medical fitness. Canada and the US have agreed to the following prohibitions:

1. Hearing-impaired drivers in Canada who do not meet the US standard will not be qualified to operate a commercial vehicle in the US.

2. Canadian drivers who have a diagnosis of epilepsy will not be qualified to operate a commercial vehicle in the US.

PART 2 – VISION

A – VISUAL ACUITY

Highway Safety/Access PEI First Reading		**Physician's/Optometrist's Initial Findings**	
Right eye	20/ _____	Right eye	20/ _____
Left eye	20/ _____	Left eye	20/ _____
Both eyes	20/ _____	Both eyes	20/

Initials _____ Date _____

Highway Safety/Access PEI Second Reading		**Physician's/Optometrist's New Findings**	
Right eye	20/ _____	Right eye	20/ _____
Left eye	20/ _____	Left eye	20/ _____
Both eyes	20/ _____	Both eyes	20/ _____

Initials _____ Date _____

B – FIELD OF VISION

Yes	**No**	
☐	☐	(a) For classes 5, 6, 7, 8 and 9, is field less than 120° with both eyes open and examined together? **Or**
☐	☐	(b) For classes 1, 2, 3 and 4, is field less than 150° with both eyes open and examined together?
☐	☐	Colour blindness? (can accurately identify red, green and amber)
☐	☐	Abnormal depth perception? (Monocular vision)

C – OPTOMETRIST/OPHTHALMOLOGIST TO COMPLETE

Yes	**No**	
☐	☐	Diseases of the eye? If "*yes*", please explain

_____

_____

_____

☐	☐	Progressive defects? At what length of time, in your opinion, might such defects have progressed to a point where re-examination would be indicated in the interest of highway safety?

_____

Based upon my examination, it is my decision that the visual performance of the above applicant **IS** ( ) **IS NOT** ( ) adequate to operate a motor vehicle with due regard for public safety.

Please indicate if a new prescription is required.

Yes ☐ **No** ☐

☐ General Practitioner ☐ Ophthalmologist ☐ Optometrist

_____

Signature

Date _____

PART 3 – MEDICAL HISTORY/PHYSICAL EXAMINATION

A – SUBSTANCE ABUSE

Yes	**No**	
☐	☐	Is there a diagnosis of chronic abuse or dependence on alcohol or other substance?

If "yes", please specify _____

_____

_____

_____

Yes	**No**	
☐	☐	If "yes", is the problem under control?
☐	☐	If "yes", has control been maintained for the last 12 months?

B – PRESCRIPTION DRUGS/MEDICATION(S)

Yes	**No**	
☐	☐	Is the patient taking any drug(s)/ medication(s) that would cause impairment of driving ability?

If "yes", please identify drug(s) (name and dosage) _____

_____

_____

_____

_____

_____

_____

C – CEREBROVASCULAR DISEASE

Is there a current history or evidence of:

Yes	**No**	
☐	☐	Cerebrovascular accidents including TIAs
☐	☐	Aortic aneurysm
☐	☐	Cerebral aneurysm
☐	☐	Peripheral arterial vascular disease
☐	☐	Diseases of the veins

☐	☐	Hospitalizations, if any, within the last five years for any condition?

_____

_____

_____

_____

D – HEARING LOSS

Does Patient wear hearing aids?

Yes	No	
☐	☐	Operating **Class 1 or 3** commercial vehicle
☐	☐	Operating **Class 2 or 4** commercial vehicle

E – MENTAL DISORDERS

Yes	No	
☐	☐	Is there a current history or evidence of cognitive disorders (dementias)?
☐	☐	If "yes", is judgment impaired sufficiently to affect driver's abilities?
☐	☐	Is there a current history or evidence of an emotional disorder likely to severely affect judgment or psychomotor ability?

F – DISEASES OF THE NERVOUS SYSTEM

Yes	No	
☐	☐	Is there a recent history of single unexplained or recurrent syncopal episodes? **IF "*YES*", PLEASE PROVIDE SATISFACTORY NEUROLOGICAL AND CARDIOVASCULAR ASSESSMENTS.**
☐	☐	Is there a history of seizures within the past 10 years? If "*yes*", when was the most recent seizure? _____
☐	☐	**Was this a case of unprovoked seizure?**
☐	☐	**Has patient been diagnosed with epilepsy? If "Yes" date of the most recent seizure:**
☐	☐	**Is there a normal neurological assessment with an EEG revealing no epileptiform activity?**
☐	☐	Is medication required to maintain seizure control? Dosage _____
☐	☐	Have medications been discontinued on physician's advice? If yes, when? _____
☐	☐	Is there a history of other disease of the nervous system? (Narcolepsy, sleep apnea, vestibular disorders, disorders of coordination and muscle control, head injury or intracranial tumor, etc.)

If "yes", please explain: _____

_____

_____

(Attach neurologist's report if required.)

G – MUSCULOSKELETAL DISABILITIES

Yes	No	
☐	☐	Is there evidence of musculoskeletal condition such as amputation, arthritis, disease of the spine, etc. likley to impair ability to operate a motor vehicle safely?

If "*yes*", please explain _____

_____

H – CARDIOVASCULAR DISEASES

Yes	No	
☐	☐	Coronary artery disease
☐	☐	Myocardial infarction If "*yes*", date of last attack: _____ Please explain _____
☐	☐	Heart transplant
☐	☐	Does this patient have an EF< 35%?
☐	☐	Does this patient have an ICD?
☐	☐	Congestive heart failure
☐	☐	Cardiac arrhythmia
☐	☐	Valvular heart disease
☐	☐	Cardiomyopathy
☐	☐	Mitral valve prolapse
☐	☐	Abnormal blood pressure

(ATTACH STRESS TESTS IF APPLICABLE)

If "yes" to any of the above, what is **the "functional classification"** (Canadian Cardiovascular Society)?

☐ CCS Class 1 ☐ CCS Class 2

☐ CCS Class 3 ☐ CCS Class 4

I – RESPIRATORY DISEASES

Yes	No	
☐	☐	Is there a current history or evidence of moderate or severe respiratory impairment?

Blood Pressure _____ Height _____ Weight _____

J – PSYCHIATRIC DISORDERS

Yes	No	
☐	☐	Is there a current history or evidence of a personality disorder manifesting in antisocial, erratic or aggressive behaviour? If "yes", has there been a favourable psychiatric assessment? **(PLEASE ENCLOSE IF AVAILABLE)**
☐	☐	Is there a current history or evidence of psychotic illness?
☐	☐	If "yes", is judgment impaired sufficiently to affect driver's abilities?

K – METABOLIC DISEASES

To be completed by the physician and reviewed in person with the applicant with diabetes.

Yes **No**

☐ ☐ Is there a **diagnosis of diabetes mellitus**?

Type of diabetes:

☐ **Type I** ☐ **Type II**

Treatment?

☐ **diet only** ☐ **insulin**

☐ **oral medication**

☐ ☐ Have you attended a formal diabetes education program? If "*yes*", please indicate year: _____

☐ ☐ Are you willing to have a source of glucose (sugar) immediately available at all times when on the road?

☐ ☐ Are you subject to "hypoglycemic unawareness" (severe low blood sugar reaction without warning which results in confusion, unconsciousness or convulsions, and which requires intervention by another person)?

If "*yes*", indicate frequency?
When was the last episode? _____

_____

Please describe how the last episode happened and the circumstances at the time:

_____

_____

_____

Yes **No**

☐ ☐ Has there been a documented blood glucose value < 2.9 mmol within the past 3 months?

1. Class 1,2,3,4 Commercial Drivers who are Insulin Dependent:
   - Annual medical required.
2. Class 1,2,3,4 Commercial Drivers controlled by Diet or Oral Medication:
   - Medical required on recommendation of physician.

Please indicate if annual medical recommended for patients controlled by diet or oral medications.

☐ **Yes** ☐ **No**

PART 4 – RECOMMENDATIONS RESPECTING MEDICAL FITNESS TO OPERATE A MOTOR VEHICLE

Date of examination _____

How long has the applicant been your patient? _____

As a result of this examination, I recommend the following:

☐ **Issue the class of license applied for without restriction.**

☐ **Do not issue license without driver's examination.**

☐ **The applicant is not medically fit to drive any class of vehicle.**

☐ **Issue a Class 5 license only.**

☐ **Do not issue license without further medical examination. [PLEASE EXPLAIN]**

Please enclose any reports or comments you feel appropriate.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Physician's Signature

PRINT PHYSICIANS' NAME _____

Address _____

Postal Code _____

Telephone (902) _____

Facsimile (902) _____

E-mail _____

☐ Family physician or

☐ Certified specialist in _____