



**CERTIFICATE OF EXAMINATION**

*For Permanent Conditions Only*

**FOR THE REPORTING PHYSICIAN:**

- Please check this box if the condition does not affect the patient's ability to drive a motor vehicle. If checked, it is not necessary to complete the Functional Ability Profile below.
- This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition that could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office at (207) 624-9000, ext. 52124 Fax: (207) 624-9319.
- A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A, M.R.S.A., Section 1258 (6).

**FUNCTIONAL ABILITY PROFILE**

This form cannot be completed without reference to the Functional Ability Profiles Booklet.

**DIAGNOSIS**  
(Please print or type)

**PROFILE LEVEL**  
*This section must be completed.*  
*Check only one box per diagnosis.*

**If COPD, needs O2 SATS**

	1.	2.	3.				4.
			A.	B.	C.	D.	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of last examination (must be within the past year): \_\_\_\_\_

How long has the applicant been your patient? \_\_\_\_\_

No Medications  
Current prescribed medication(s) and side effects experienced at present: \_\_\_\_\_

\_\_\_\_\_

Reliability in taking medications: \_\_\_\_\_

Date of last seizure or loss of consciousness: \_\_\_\_\_

**PHYSICIAN'S COMMENTS (Important – please describe physical and/or cognitive deficits.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_