State of Vermont
DEPARTMENT OF MOTOR VEHICLES
120 STATE STREET
Montpelier, VT 05603-0001

dmv.vermont.gov
[Phone] 802.828.2000
[Fax] 802.828.2098
[TTD] 800.253.0191

UNIVERSAL MEDICAL EVALUATION/PROGRESS REPORT

➔ **THIS EVALUATION MUST BE COMPLETED IN FULL OR IT WILL BE RETURNED** ➔

ANY MEDICAL CHARGES INCURRED ARE THE RESPONSIBILITY OF THE PATIENT

PLEASE INDICATE REASON FOR THE EVALUATION

Complete Sections A, B, D & E if you are selecting one of the four reasons below. See front and back of form.

- ❑ Applying for a Vermont License/Permit
- ❑ School Bus Endorsement (Type II)
- ❑ Department Request
- ❑ New/Update Medical Condition

Complete ALL Sections if requesting a DISABLED PLACARD OR PLATES. See front and back of form.

- ❑ Disabled Parking Placard (must be accompanied by a Disabled Parking Placard Application ~ TA-VD-120)
- ❑ Disabled Parking Plate (must be accompanied by a Registration, Tax and Title Application ~ TA-VD-119)

A NOTE TO PARKING PLACARD APPLICANTS: THE INFORMATION IN THIS MEDICAL MAY BE CONSIDERED IN DETERMINING YOUR LICENSE STATUS

SECTION A - TO BE COMPLETED BY APPLICANT

PATIENT'S NAME:	
PATIENT'S MAILING ADDRESS:	Street / Road / Box Number
	City / State / Zip Code

Physical Address – If Different From Mailing Address

GENDER: ❑ MALE ❑ FEMALE

CHECK-MARK THE APPROPRIATE BOX IF THE ABOVE IS A CHANGE TO YOUR: ❑ MAILING ADDRESS ❑ PHYSICAL ADDRESS

DATE OF BIRTH	SOCIAL SECURITY NUMBER	VT DRIVER LICENSE/ID NUMBER (If Applicable)

IF THIS IS A NAME CHANGE, LIST FORMER NAME:

I CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. STATEMENTS AND WARRANTS HEREIN ARE CERTIFIED UNDER PENALTY OF 23 VSA §202 & §203.

➢ APPLICANT'S SIGNATURE:

SECTIONS B, C, D & E – TO BE COMPLETED BY MEDICAL EXAMINER

SECTION B

1. Patient has been under my care for ________ years.
2. Check-mark any/all of the following conditions that apply:

❑ **SEIZURES**	❑ **CANCER**	❑ **SPINAL INJURY**	❑ **HYPERTENSION**
❑ **DIABETES**	❑ **COPD**	❑ **ARTHRITIS/DEGENERATIVE JOINT DISEASE**	

❑ **AMPUTATION:**
ARM: ❑ Left ❑ Right
LEG: ❑ Left ❑ Right
Describe cause and extent (example: at elbow, below knee) of amputation:
____

❑ **PERMANENT DISABILITY/ CONDITION**:
Specify: ________________________________

❑ **PSYCHIATRIC DISORDER**:
Specify: ________________________________

3. Blood pressure reading is required for **all school bus driver medicals**. For other licensed drivers, only indicate if a medical condition exists.

Systolic:		**Diastolic:**	

DEPARTMENT USE ONLY SECTION			MEDICAL DATE:
RATER #:	TRANSACTION TYPE:	TYPE:	/
	❑ ADD ❑ UPDATE	❑ A – SCHOOL BUS ❑ B – NOT STABLE ❑ D – STABLE	CURRENT YEAR / CURRENT MONTH

CONTINUED ~ SECTIONS C, D & E – TO BE COMPLETED BY MEDICAL EXAMINER

SECTION C – PARKING PLACARD/PLATES

I hereby attest to the fact that at the time of the examination the applicant:

Check-mark the applicable disability. **One must be check-marked**.

- ❑ Has an irreversible visual impairment, or
- ❑ Has an irreversible ambulatory disability within the meaning of 23 VSA §304a.

SECTION D – MEDICAL EXAMINER'S OPINION

1. I have examined the patient and in my opinion: (Check-mark one of the statements below.)
   - ❑ The patient **IS NOT** medically fit to drive any motor vehicle on the highway.
   - ❑ There are no reasonable **medical** grounds to limit driving privileges.
   - ❑ The patient is medically fit to drive a motor vehicle, however, they should:
     - ❑ Submit progress reports to the Department of Motor Vehicles every: _________ Months _________ Years
     - ❑ Be further evaluated for driving ability.

   Comments: ____

   ____

2. **Patient's condition is totally stable:** ❑ **Yes** ❑ **No**

SECTION E – MEDICAL EXAMINER'S CERTIFICATE

THIS FORM MUST BE COMPLETED BY A LICENSED PHYSICIAN, EXCEPT AS STATED BELOW.

1. If the medical is for School Bus requirements, it must be signed by a Licensed Physician, Physician Assistant or a Nurse Practitioner.

2. If the applicant has or is applying for a Vermont license, without a School Bus endorsement, the medical must be signed by a Licensed Physician. **Exception:** A Physician Assistant may sign the medical, if co-signed by a Licensed Physician.

3. If the applicant is applying for Disabled Parking Placard or Disabled Parking Plates, the medical must be signed by a Licensed Physician, Certified Physician Assistant or Licensed Advanced Practice Registered Nurse.

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. STATEMENTS AND WARRANTS MADE HEREIN ARE CERTIFIED UNDER PENALTY OF 23 VSA § 202.

DATE OF EXAM										DATE OF EXAM MUST BE ENTERED AT LEFT AND BE WITHIN THE LAST 6 MONTHS TO BE ACCEPTABLE.
		/			/					

MEDICAL EXAMINER'S SIGNATURE	DATE
MEDICAL EXAMINER'S NAME (PRINT CLEARLY)	**PHONE NUMBER**

MEDICAL EXAMINER'S MAILING ADDRESS	STREET/ROAD/BOX NUMBER
	CITY/STATE/ZIP CODE

CLASSIFICATION OR SPECIALTY	TITLE	LICENSE STATE	LICENSE #