Form 420010 (05-26)

IOWA DEPARTMENT OF TRANSPORTATION
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SUPPLEMENTAL MEDICAL REPORT

To be completed following the completion of occupational therapy or driver rehabilitation.

For Office Use Only

Customer Number: _____ **Date Requested**: _____
Reason Requested:

Type of license this customer currently holds:

☐ Class C non-commercial license ☐ Class D chauffeur license ☐ Motorcycle endorsement
☐ Class A commercial license ☐ Class B commercial license ☐ Class C commercial license

CDL Endorsements: ☐ Passenger ☐ School Bus ☐ Hazmat ☐ Tank ☐ Double and Triple Trailers

Date Received: _____ ☐ FILE (DOC98) ☐ FORWARD (98DOC)

Section A: To be Completed by the Driver's License Applicant

Notice To Applicant: The Department may require a medical report if we believe a health condition could affect your ability to drive safely. We may delay your license until we get this information.

Instructions: Complete Section A, then take this form to your doctor to fill out Section B.

Your medical report is private unless you give written permission to share it. You must pay for any exams or report costs. All requested information is required. If you don't provide it, your Iowa driving privileges may be denied or withdrawn.

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Street: _____ **City:** _____**State:** _____ **Zip Code:** _____

Driver's License Number: _____ **Date of Birth:** _____ **Phone Number:** _____

Authorization: I allow my doctor(s) to share medical information with the Iowa Department of Transportation about my ability to drive safely. I understand this information may be reviewed by the Medical Advisory Board to give the Department an opinion. The Board will only see my information by number, not by name. A copy of this authorization is as valid as the original.

Signature of license applicant: _____ Date: _____

Please take this form to your doctor to fill out Section B (reverse side).

Section B: To be Completed by a Licensed Physician

Note to physician: If the applicant requests, this information will be shared with them or their chosen representative. The Department may also require additional testing (such as a written or driving test) to confirm the applicant's ability to drive. Please provide the medical details below so we can determine if the applicant can safely operate a motor vehicle.

1. **Did you refer this patient to Occupational Therapy or Driver Rehabilitation?** ☐ **Yes** ☐ **No**

   If no, specify the name of the referring physician: _____

2. **Are you aware of this patient's medical history and have you received and reviewed the final OT/Driver Rehab report?**

   ☐ **Yes** Name of Occupational Therapy or Driver Rehab provider_____

   Date Occupational Therapy or Driver Rehab completed _____

   ☐ **No** **Remarks:**

3. **Do your findings indicate that this patient is:**
   a. **Physically qualified to operate a motor vehicle with safety?** ☐ **Yes** ☐ **No**

   b. **Mentally qualified to operate a motor vehicle with safety?** ☐ **Yes** ☐ **No**

   Remarks:

4. **Do you recommend driving restrictions?** ☐ **Yes** ☐ **No**

   Recommended restrictions:

   ☐ No driving when headlights are required ☐ No interstate or freeway driving
   ☐ Maximum speed _____ mph ☐ Limited to _____miles from home
   ☐ Other (specify) _____

5. **Should the department require another Medical Report in:**

   ☐ 6 months ☐ 1 year ☐ 2 years ☐Other _____

   ☐ No follow-up Medical Report recommended by physician

   Remarks:

For this Medical Report to be considered:

- The date of this report must be within 6 months of application for a license.
- The medical report must be signed by a physician licensed to practice medicine and or surgery: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PAC, PA) or Advanced Registered Nurse Practitioner (ARNP).

Licensed Physician's Name (please print): _____ **Specialty:** _____

Medical License Number: _____ **Phone Number:** _____

Street Address: _____ **City:** _____**State:** _____ **Zip Code:** _____

Licensed Physician's Signature: _____ **Date:** _____