Phone: 724-221-4614 Email: resslersdrivingacademy

Fax: 724-879-8656 Website: resslersdrivingacademy.com

Driver Evaluation Physician Medical Approval Form

A Physician Must Complete This Form Before The Driving Evaluation Is Scheduled*

Date: _____ Physician Name: _____

Physician Address: _____

Phone: _____ Fax: _____

Physician License Number: _____

**Ressler's Driving Academy, LLC has been given my medical permission to conduct a driving evaluation for the customer below:

Physician Signature: _____

Customer Information (completed by physician)

Customer Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Height: _____ Has Driver License/Permit: Y or N

Diagnosis: _____ Date of Onset: _____

Place a check mark next to the condition(s) that apply to the customer.

___ Amputation(s) ___ Seizure Disorder ___ Vision Problems ___ Diabetes

___ Hearing Problem ___ Paralysis ___ Neuropathy of Legs/Feet

___ Alcoholism/Drug Use ___ Cognitive Disorder(s) ___ Motor Disorders ___ Cardiac Conditions

Please provide a brief description of the condition.

List medications that may affect customer's driving ability

Medication Name	For What Condition	Possible Effects on Driving
1.		
2.		
3.		

Please list additional medications on the back of this page.