Click here to START or CLEAR, then hit the TAB button

WASHINGTON STATE DEPARTMENT OF LICENSING

Physical Examination Report

You can use this form to provide us with information regarding a driver's ability to safely operate a motor vehicle.
Mail completed form to: **Medical Unit, Department of Licensing, PO Box 9030, Olympia, WA 98507**, or fax **(360) 570-7893**.

Driver – Complete this section and sign the consent to release information. Have your medical examiner complete this form. The medical examiner will send the completed form to us.

Name *(Last, First, Middle)*		Date of birth	Today's date
(Area code) Daytime telephone number	(Area code) Home telephone number	Driver license number	

Consent to release information

I authorize _____, a licensed physician M.D., D.O., Naturopath, Psychiatrist, Psychologist, R.N., A.R.N.P., P.A., or P.A.C. to provide information regarding my medical condition from my examination ***conducted within the past 3 months****. I understand the Department of Licensing will use this information to arrive at a decision regarding my ability to safely operate a motor vehicle.*

X When this form is completed and printed, driver signs here
Driver signature

X When this form is completed and printed, parent signs here if driver is a minor
Signature of parent (if minor)

Medical examiner – Please complete the following and mail to: **Medical Unit, Department of Licensing, PO Box 9030, Olympia, WA 98507** or fax **(360) 570-7893**.

1. Does this individual have a condition which may cause a loss of consciousness or control? . . . . . ☐ Yes ☐ No
   If yes, indicate month and year of most recent occurrence: _____
   Comments

2. Does this individual have a condition which may interfere with driving? . . . . . ☐ Yes ☐ No
   Comments

3. Should this individual be required to submit periodical medical examination reports as a condition of licensing? . . . . . ☐ Yes ☐ No
   If yes, how often? ☐ 6 months ☐ 1 year ☐ 2 years
   Comments

Medical examiner name		Professional license number	Exam date
Street address			
City	State	ZIP code	(Area code) Telephone number

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Date and place

X When this section is completed, medical examiner signs here
Signature of medical examiner

If this Department has reason to believe that a person is suffering from a physical or mental disability or disease that may affect that person's ability to drive a motor vehicle, we must evaluate whether the person is able to safely drive. As part of the evaluation, we may require the person to obtain a statement signed by a licensed physician or other proper authority designated by us, certifying the person's condition. RCW 46.20.041; 46.20.305.

We are committed to providing equal access to our services.
If you need accommodation, please call (360) 902-3900 or TTY (360) 664-0116.