DR-11 - INITIAL REPORTING FORM

PLEASE TYPE OR PRINT ALL INFORMATION IN BLACK INK

DEPARTMENT OF PUBLIC SAFETY
DRIVER RECORDS DEPARTMENT/ MEDICAL
P. O. BOX 958
JACKSON, MISSISSIPPI 39205-0958
601-987-1225 or 601-987-1231

NAME (PRINT) OF INDIVIDUAL ISSUING DR11 FORM TO DRIVER
_______________________ BADGE # ________

ALL INFORMATION IS CONFIDENTIAL RELATING TO THE LICENSED DRIVER AND IS TO BE FILLED OUT BY THE DOCTOR.

SECTION A PATIENT'S SIGNATURE ______________________ DATE __________

I hereby authorize and request the physician whose signature appears below and who has examined me to release all information and findings contained herein to the Mississippi Department of Public Safety for use in making a final determination on my application for a driver license, and I further authorize the Department of Public Safety to release this information to such individuals or groups as may be deemed necessary and appropriate.

SECTION B PATIENT INFORMATION

LAST NAME(S)	JR. ETC	FIRST NAME	MIDDLE NAME

HEIGHT FEET INCHES	SEX	EYE COLOR	DATE OF BIRTH MONTH DAY YEAR	TELEPHONE NUMBER ( )	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE #

STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF EXAMINATION: ____________ **HOW LONG HAVE YOU BEEN TREATING THIS PATIENT?** ________

SECTION C DIAGNOSIS OF DISORDER OR DISABILITY: *Please check (/) Appropriate Items*

□Orthopedic - Spastic or Paralyzed Muscles: Describe ______________________
□ Loss or Impairment of a Foot, Leg, Finger Thumb, or Hand-Condition: ______________
□ Unstable Diabetes
□ Cerebral Vascular Disease
□ Cardiovascular Disease
□ Loss of consciousness - Cause: ______________
□ Neurological Disorder
□ Neuromuscular Disorder: ______________
□ Single Seizure: DATE of SEIZURE: ______________

□ Cognitive Impairment: ______________
□ Neuropsychiatric Disorder: ______________
□ Psychiatric Disorder : ______________
□ Alcohol Abuse: BAC ______________
□ Drug or Controlled Substance Abuse: ______________
□ Vision Deficiency: 9 Acuity 9 Visual Fields
□ Other Medical Condition that would interfere with the patient's ability to drive, such as Rehab. Explain: ______________

NOTE: A seizure disorder - more than one seizure or a single seizure of electrically diagnosed epilepsy.

Patient meets following seizure waiver, therefore no action should be taken on the driving privilege:

□ 2 year history of strictly a nocturnal pattern of seizures or a pattern of seizures occurring only immediately upon awakening
□ 2 year history of a specific prolonged aura accompanied by sufficient warning
□ Patient has been seizure free for the previous 6 months and above referenced seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance.

SHOULD THIS INDIVIDUAL LOSE HIS/HER DRIVING PRIVILEGE IMMEDIATELY? .... □ YES □ NO
IF NOT, DOES THE CONDITIONS(S) WARRANT FURTHER INVESTIGATION OF DRIVING COMPETENCY BY THIS DEPARTMENT: □ YES □ NO

SECTION D **THE ABOVE NAMED APPLICANT IS BEING REQUIRED TO UNDERGO A MEDICAL EXAMINATION AND AUTHORIZED BY MISSISSIPPI CODE OF 1972, REVISED AND ANNOTATED, SECTION 63-1-9, D, AND 63-1-53, E, RELATING TO THE APPLICANT'S ABILITY TO OPERATE A MOTOR VEHICLE SAFELY. THE COMPLETED MEDICAL REPORT WILL BE USED BY THE COMMISSIONER OF PUBLIC SAFETY, OR HIS AUTHORIZED AGENT(S).**

HEALTH CARD PROVIDER'S NAME   SPECIALITY   STATE MEDICAL LICENSE NUMBER ______________

STREET ADDRESS   CITY   STATE/ZIP CODE

TELEPHONE: ______________ FAX: ______________

I hereby state that the facts above are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of the state laws of Mississippi. (Relating to unsworn falsification to authorities) punishable by Mississippi laws. Doctor please mail this form to the address above. **(NOT TO BE COMPLETED BY A NURSE PRACTITIONER)**

______________________ ______________
HEALTH CARE PROVIDER'S SIGNATURE (Doctor Only)   DATE