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
601-987-1224

ALL INFORMATION IS CONFIDENTIAL RELATING TO THE LICENSED DRIVER .

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 TO BE COMPLETED BY PATIENT

Last Name: First Name: Middle Name:

Gender: ☐M ☐F	Date of Birth	Telephone Number	Social Security Number	Driver's License #

Street Address: City: State: Zip code:

SECTION C The above named applicant is being required to undergo a medical examination as 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 safely operate a motor vehicle. The completed medical report will be used by the Commissioner of Public Safety, or his authorized agent (s).

SECTION D TO BE COMPLETED BY PHYSICIAN **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: ☐ Acuity ☐ Visual Fields
☐ Other Medical Condition that would interfere with the patient's ability to drive, such as Rehab. Explain: _____

☐ Autism Spectrum Diagnosis

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 yes, please attach supporting narrative.
If not, does the condition(s) warrant further investigation of driving competency by this department? ☐ YES ☐ NO

Physicians Name: _____ Specialty: _____ State Medical License# _____

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. The physician's office must mail this form to the address above.

Physician's Signature	Today's Date	Date of Examination