



# Driver's Medical Certificate

Transportation, Infrastructure and Energy, Highway Safety Division

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This certificate is to be used to record the results of a medical examination by a physician on behalf of an application for a driver's license issued pursuant to the *Highway Traffic Act* and Regulations.

Pursuant to Section 70(6) of the *Highway Traffic Act*, the Registrar may, before issuing a driver's license, or anytime after he has issued the license to the person, require the person to undergo a medical examination and produce a certificate on such form as the Registrar may provide to determine whether the person is physically and mentally competent to operate any class of motor vehicle.

In determining whether or not a person is medically fit to operate a motor vehicle, the Registrar and Highway Safety Medical Review Board shall apply the standards set out in the most recent edition of the Medical Standards for Drivers manual published by the Canadian Council of Motor Transport Administrators.

**Important Note:** The costs associated with the completion of this report are the responsibility of the driver/patient.

**Personal Information on this form is collected under the authority of section 70 of Prince Edward Island's *Highway Traffic Act* and will be used for the purpose of the issuance of a driver's license to an applicant. If you have any questions about this collection of personal information, you may contact the Department of Transportation, Infrastructure and Energy, Registrar of Motor Vehicles, PO Box 2000, Charlottetown, PE C1A 7N8.- Telephone: (902)-368-5223.**

## PART I – DRIVER/PATIENT INFORMATION - PLEASE COMPLETE

Name \_\_\_\_\_ Driver's License # \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Telephone (home) ( ) \_\_\_\_\_

Postal Code \_\_\_\_\_ (work) ( ) \_\_\_\_\_

Reason \_\_\_\_\_

Issuing Person \_\_\_\_\_ Date \_\_\_\_\_

This certificate is submitted in support of my application to obtain or retain the following class of driver's license.

- |  |   |   |   |  |
|--|---|---|---|--|
| Class 1 <input type="radio"/><br>(tractor-trailer) | Class 2 <input type="radio"/><br>(bus/school bus)                   | Class 3 <input type="radio"/><br>(straight truck)     | Class 4 <input type="radio"/><br>(ambulance/bus/taxi) | Class 5 <input type="radio"/><br>(passenger car/light truck) |
|  | English <input type="checkbox"/><br>French <input type="checkbox"/> | Class 7 <input type="radio"/><br>(instruction permit) | Class 8 <input type="radio"/><br>(moped)              | Class 9 <input type="radio"/><br>(farm tractor)              |
| Class 6 <input type="radio"/><br>(motorcycle)      |   |   |   |  |

### Driver's Release of medical and driving record information to Highway Safety Division and for Highway Safety Division to report to Physician

I certify that the foregoing information is, to the best of my knowledge, correct.

\_\_\_\_\_  
Signature of Driver/Patient

\_\_\_\_\_  
Date

### COMMERCIAL VEHICLE DRIVERS

Effective March 31, 1999, Canadian commercial vehicle drivers will no longer be required to carry a medical card for inspection by US officials as proof of medical fitness. Canada and the US have agreed to the following prohibitions:

1. Insulin-dependent diabetics will not be qualified to operate in the US.
2. Hearing-impaired drivers in Canada who do not meet the US standard will not be qualified to operate a commercial vehicle in the US.
3. Canadian drivers who have a diagnosis of epilepsy will not be qualified to operate a commercial vehicle in the US.

## PART 2 – VISION

### A – VISUAL ACUITY

Highway Safety/Access PEI	Physician's/Optomtrist's
First Reading	Initial Findings
Right eye 20/_____	Right eye 20/_____
Left eye 20/_____	Left eye 20/_____
Both eyes 20/_____	Both eyes 20/_____

Initials \_\_\_\_\_ Date \_\_\_\_\_

Highway Safety/Access PEI	Physician's/Optomtrist's
Second Reading	New Findings
Right eye 20/_____	Right eye 20/_____
Left eye 20/_____	Left eye 20/_____
Both eyes 20/_____	Both eyes 20/_____

Initials \_\_\_\_\_ Date \_\_\_\_\_

### B – FIELD OF VISION

- | Yes                   | No                    |  |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | (a) For classes 5, 6, 7, 8 and 9, is field less than 120° with both eyes open and examined together? <b>or</b> |
| <input type="radio"/> | <input type="radio"/> | (b) For classes 1, 2, 3 and 4, is field less than 150° with both eyes open and examined together?              |
| <input type="radio"/> | <input type="radio"/> | Colour blindness? (can accurately identify red, green and amber)   |
| <input type="radio"/> | <input type="radio"/> | Abnormal depth perception? (Monocular vision)  |

### C – OPTOMETRIST/OPHTHALMOLOGIST TO COMPLETE

- |                       |                       |  |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Diseases of the eye?<br>If "yes", please explain _____ |
|-----------------------|-----------------------|--|
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- |                       |                       |   |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Progressive defects?<br>At what length of time, in your opinion, might such defects have progressed to a point where re-examination would be indicated in the interest of highway safety? |
|-----------------------|-----------------------|---|
- \_\_\_\_\_

Based upon my examination, it is my decision that the visual performance of the above applicant IS ( ) IS NOT ( ) adequate to operate a motor vehicle with due regard for public safety.

Please indicate if a new prescription is required.

Yes  No

- |                       |                      |
|-----------------------|----------------------|
| <input type="radio"/> | General Practitioner |
| <input type="radio"/> | Ophthalmologist      |
| <input type="radio"/> | Optometrist          |

\_\_\_\_\_  
*Signature*

Date \_\_\_\_\_

## PART 3 – MEDICAL HISTORY/PHYSICAL EXAMINATION

### A – SUBSTANCE ABUSE

- | Yes                   | No                    |  |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Is there a diagnosis of chronic abuse or dependence on alcohol or other substance? |

If "yes", please specify \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- |                       |                       |   |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | If "yes", is the problem under control?                       |
| <input type="radio"/> | <input type="radio"/> | If "yes", has control been maintained for the last 12 months? |

### B – PRESCRIPTION DRUG(S)/MEDICATION(S)

- | Yes                   | No                    |  |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Is the patient taking any drug(s)/ medication(s) that would cause impairment of driving ability? |

If "yes", please identify drug(s) (name and dosage) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### C – CEREBROVASCULAR DISEASES

Is there a current history or evidence of:

- | Yes                   | No                    |  |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Cerebrovascular accidents including TIAs |
| <input type="radio"/> | <input type="radio"/> | Aortic aneurysm                          |
| <input type="radio"/> | <input type="radio"/> | Cerebral aneurysm                        |
| <input type="radio"/> | <input type="radio"/> | Peripheral arterial vascular disease     |
| <input type="radio"/> | <input type="radio"/> | Diseases of the veins                    |

- |                       |                       |  |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Hospitalizations, if any, within the last five years for any conditions? |
|-----------------------|-----------------------|--|
- \_\_\_\_\_
- \_\_\_\_\_

D – HEARING LOSS

Does Patient wear hearing aids?

- Yes No
Operating Class 1 or 3 commercial vehicle
Operating Class 2 or 4 commercial vehicle

E – MENTAL DISORDERS

- Yes No
Is there a current history or evidence of cognitive disorders (dementias)?
If 'yes', is judgment impaired sufficiently to affect driver's abilities?
Is there a current history or evidence of an emotional disorder likely to severely affect judgment or psychomotor ability?

F – DISEASES OF THE NERVOUS SYSTEM

- Yes No
Is there a recent history of single unexplained or recurrent syncopal episodes? IF 'YES', PLEASE PROVIDE SATISFACTORY NEUROLOGICAL AND CARDIOVASCULAR ASSESSMENTS.
Is there a history of seizures within the past 10 years? If 'yes', when was the most recent seizure?
Was this a case of unprovoked seizure?
Has patient been diagnosed with epilepsy? If 'Yes' date of the most recent seizure
Is there a normal neurological assessment with an EEG revealing no epileptiform activity?
Is medication required to maintain seizure control? Dosage
Have medications been discontinued on physician's advice? If 'yes', when?
Is there a history of other disease of the nervous system? (Narcolepsy, sleep apnea, vestibular disorders, disorders of coordination and muscle control, head injury, or intracranial tumour, etc.)

If 'yes', please explain

(Attach neurologist's report if required.)

G – MUSCULOSKELETAL DISABILITIES

- Yes No
Is there evidence of musculoskeletal condition such as amputation, arthritis, disease of the spine etc. likely to impair ability to operate a motor vehicle safely?

If 'yes', please explain

H – CARDIOVASCULAR DISEASES

- Yes No
Coronary artery disease
Myocardial infarction
If 'yes', date of last attack
Please explain

- Heart transplant
Does this patient have an EF <= 35%?
Does this patient have an ICD?

If 'yes' to any of the above, what is the 'functional classification' (Canadian Cardiovascular Society)?

- CCS Class 1 CCS Class 2
CCS Class 3 CCS Class 4

- Congestive heart failure
Cardiac arrhythmia
Valvular heart disease
Cardiomyopathy
Mitral valve prolapse
Abnormal blood pressure

(ATTACH STRESS TESTS IF APPLICABLE.)

I – RESPIRATORY DISEASES

- Yes No
Is there a current history or evidence of moderate or severe respiratory impairment?

Blood Pressure Height Weight

J – PSYCHIATRIC DISORDERS

- Yes No
Is there a current history or evidence of a personality disorder manifesting in antisocial, erratic or aggressive behaviour? If 'yes', has there been a favourable psychiatric assessment? (PLEASE ENCLOSE IF AVAILABLE).

- Is there a current history or evidence of psychotic illness?

- If 'yes', is judgment impaired sufficiently to affect driver's abilities?

**K – METABOLIC DISEASES**

*To be completed by the physician and reviewed in person with the applicant with diabetes.*

**Yes      No**

       Is there a **diagnosis of diabetes mellitus?**

**Type of diabetes:**

**Type I**     **Type II**

**Treatment?**

**diet only**     **insulin**

**oral medication**

       Have you attended a formal diabetes education program? If "yes", please indicate year \_\_\_\_\_

       Are you willing to have a source of glucose (sugar) immediately available at all times when on the road?

       **Are you subject to "hypoglycemic unawareness" (severe low blood sugar reaction without warning which results in confusion, unconsciousness or convulsions, and which requires intervention by another person)?**

If "yes", indicate frequency? \_\_\_\_\_

When was the last episode?  
\_\_\_\_\_

Please describe how the last episode happened and the circumstances at the time:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Yes      No**

       Has there been a documented blood glucose value < 2.9 mmol within the past 3 months?

1. Class 1,2,3,4 Commercial Drivers who are Insulin Dependent:  
- Annual medical required.

2. Class 1,2,3,4 Commercial Drivers controlled by Diet or Oral Medication:  
- Medical required on recommendation of physician.

**Please indicate if annual medical recommended for patients controlled by diet or oral medications.**

**Yes**     **No**

**PART 4 – RECOMMENDATIONS RESPECTING MEDICAL FITNESS TO OPERATE A MOTOR VEHICLE**

Date of examination \_\_\_\_\_

How long has the applicant been your patient? \_\_\_\_\_

**As a result of this examination, I recommend the following:**

- Issue the class of license applied for without restriction.
- Do not issue license without driver's examination.
- The applicant is not medically fit to drive any class of vehicle.
- Issue a Class 5 license only.
- Do not issue license without further medical examination. [PLEASE EXPLAIN]

*Please enclose any reports or comments you feel appropriate.*

\_\_\_\_\_  
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\_\_\_\_\_

***Physician's signature***

**PRINT PHYSICIAN'S NAME** \_\_\_\_\_

Address \_\_\_\_\_

Postal code \_\_\_\_\_

Telephone (    ) \_\_\_\_\_

Facsimile (    ) \_\_\_\_\_

E-Mail \_\_\_\_\_

- Family physician, or
- Certified specialist in \_\_\_\_\_