Government of **Western Australia**
Department of **Transport**
Driver and Vehicle Services

M107A

Medical Assessment Certificate
Fitness to Drive

Please read the detailed medical assessment instructions (M106A) for the applicant and health professional.

Post to: The Occupational Health Physician
C/- Department of Transport
GPO Box R1290, PERTH WA 6844
Please mark as Confidential

Applicant details - to be completed by applicant or Department of Transport

FAMILY NAME	
GIVEN NAMES	DATE OF BIRTH
RESIDENTIAL ADDRESS	

I consent to any reporting health professional named on this form releasing information to the Department of Transport (DoT) and DoT contacting any reporting health professional named on this form to obtain any further information relevant to my fitness to drive.

SIGNATURE

Licence details current and proposed.Please circle the class/es of vehicle you are currently authorised to drive or are proposing to drive.

STANDARD	PRIVATE			COMMERCIAL						
TYPE OF VEHICLE	MOTOR CAR	MOTORCYCLE	LIGHT RIGID	MEDIUM RIGID	HEAVY RIGID	HEAVY COMBINATION	MULTI COMBINATION	DRIVER INSTRUCTORS	TAXI	CARRY PASSENGERS FOR REWARD
CLASS	☐ C	☐ R	☐ LR	☐ MR	☐ HR	☐ HC	☐ MC	☐ DI	☐ T EXTENSION	☐ F EXTENSION

CLASS/ES OF VEHICLE CURRENTLY AUTHORISED TO DRIVE:

EXTENSION/S HELD:

APPLIED FOR AUTHORISATION TO DRIVE VEHICLES OF CLASS/ES:

EXTENSION/S APPLIED FOR

☐ Licence/extension application

☐ Current licence

REASON FOR REFERRAL

DRIVER'S LICENCE / PERMIT NO:	EXPIRY DATE:
APPLICATION TYPE:	
APPLICANT HAS DECLARED THAT: **HE/SHE SUFFERS FROM** **HE/SHE TAKES AS MEDICATION**	

The Department of Transport has reason to believe that the following background information may be of some assistance:

Enquiries 13 11 56

Assessment of Fitness to Drive - to be completed by health professional

Please answer all questions below:

1. Were you familiar with the patient's medical history prior to this examination? ☐ Yes ☐ No

2. I have attended this patient professionally since:_____(Month/Year)

Visual Acuity:

☐ Uncorrected			☐ Corrected		
R	L	B	R	L	B
6/	6/	6/	6/	6/	6/

Blood Pressure Reading _____

Other Medical Condition _____

3. Clinical Findings **Please provide where applicable** • details of medical condition • treatments • history of episodes • details of control or complication/s • conditions of licence • results of relevant investigations e.g. Hba1c for diabetes	_____ _____ _____ _____ _____

4. In my opinion the person who is the subject of this report:

a. ☐ **Meets the relevant medical criteria -** Fit to drive

b. ☐ **Does not meet the relevant medical criteria -** Not fit to drive
Criteria not met - (Please detail relevant clinical findings at question 3)

c. ☐ **May be suitable to drive, subject to conditions -** Fit to drive with conditions
(Please enter relevant clinical findings at question 3)
Note: A conditional licence will not be issued unless adequate supporting information is provided by the examining health professional to the relevant department.

5. Requires specialist assessment ☐ Yes ☐ No Please specify_____

☐ **Occupational Therapist assessment (may include driving assessment)**

☐ **On-road practical driving assessment by the Department of Transport**

6. Recommended re-assessment period ☐☐ years ☐☐ months

7. I have discussed this recommendation with patient ☐ Yes ☐ No

8. I have examined the patient according to: ☐ **Commercial vehicle standards** (Heavy vehicle drivers, class MR and above, F&T extension holders, Dangerous goods vehicle driver, Driving Instructors)
OR
☐ **Private vehicle standards**

DATE OF EXAMINATION	DATE OF REPORT	SURGERY STAMP
REPORTING PROFESSIONAL'S NAME AND QUALIFICATION		

I certify that I have examined the above-mentioned patient in accordance with the relevant National Medical Standards (private or commercial vehicle standards) as set out in *Assessing Fitness to Drive* Guidelines.

TELEPHONE ( )	FAX ( )	SIGNATURE	☐ FURTHER COMMENTS ON MEDICAL CONDITION(S) AFFECTING SAFE DRIVING ARE ATTACHED
EMAIL ADDRESS			