

Page 1 of 2

DR. H.

Dr.

Sub.
Date

Y/A

M

Qu

If not shown, please print last name, then first name and address. / Si/s ne sont pas indiqués, veuillez écrire votre nom de famille, suivi de votre prénom et adresse.

Class of Licence Desired Catégorie de permis désirée		Office Use Only Reservé au Bureau	
<div></div>		Name of Recipient Nom	
Sex Sexe		M or F M ou F	
Date of Birth Date de naissance		M or F M ou F	
Full Name Nom complet		M or F M ou F	
Full Name Nom complet		M or F M ou F	
Reason for Medical / Reason de l'examen		M or F M ou F	
1. <input type="checkbox"/> Original Driver's License Primo obtention du permis		2. <input type="checkbox"/> Regular Renewal Renouvellement régulier	
3. <input type="checkbox"/> Change of Class Changement de catégorie		4. <input type="checkbox"/> Renewal after Suspension Renouvellement après suspension	

Driver's Certificate and Release of Information

I certify that the foregoing information is to the best of my knowledge correct and agree to this report and any future report from this examination only being given to the Ministry of Transportation. The fee for this examination is not the responsibility of the ministry or its service provider.

Telephone Number

Numéro de téléphone

Business / Travail

Home / Domicile

Driver's Signature / Signature du/de la conducteur(trice)

Date

Y/A

M

Qu

Complete Health History

To be completed by examining physician.

YES answers should be explained on the reverse side under History Details.

- | | Yes/Oui | No/Non |
|---|--------------------------|--------------------------|
| 1. Diseases of Senses (Deafness, Vertigo, Visual Deficiencies, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Cardiovascular Diseases (Heart Failure, Angina, Infarction, Embolism, Arrhythmia, Syncope, Surgery, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Respiratory Diseases (Asthma, Chronic Bronchitis, Emphysema, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Diseases of the Musculo-Skeletal System (Fracture(s) or Amputation, Arthritis, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Metabolic Diseases (Diabetes (+) (-), Hypoglycemia, Thyroid, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Psychiatric Disorders (Psychoneurosis, Psychosis, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Addictions (Alcohol, Sedatives, Tranquillizers, Narcotics, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other Diseases (Blackouts, Fainting Spells, Anemia, Cancer, Blood Dyscrasias, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Neurological Diseases (Seizures, Cerebrovascular Diseases, Parkinson's Disease, Multiple Sclerosis, Dementia, Head Injury, Mental Retardation, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

Date of first seizure

Date of last seizure

Date of Examination

Y/A

M

Qu

Antécédents médicaux

The present report must be filled in by the medical professional. Please explain on the reverse side the affirmative answers.

- | | | |
|--|--------------------------|--------------------------|
| 1. Maladies touchant les sens (surdité, vertige, déficiences visuelles, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Maladies cardio-vasculaires (insuffisances cardiaques, angine, infarctus, embolie, arythmie, syncope, chirurgie, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Maladies respiratoires (asthme, bronchite chronique, emphysème, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Maladies touchant le système musculo-squelettique (fracture(s) ou amputation, arthrite, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Maladies touchant le métabolisme (diabète (+) (-), hypoglycémie, thyroïde, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Troubles psychiatriques (psychonévrose, psychose, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Dependances (alcool, sédatifs, tranquillisants, stupéfiants, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Autres maladies (maladies neurologiques, anémie, cancer, dyscrasie, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Maladies neurologiques (crises, maladies cérébro-vasculaires, maladie de Parkinson, sclérose en plaques, démence, traumatisme crânien, retardation mentale, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

Date of the previous crisis

Date of the previous crisis

Date of the examination

Medical Doctor Report Ontario

M Walker



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