OMB APPROVAL NO 1405-XXXX
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: XX MINUTES

U.S. Department of State
Bureau of Medical Services

DRIVER MEDICAL EVALUATION: SEIZURE/EPILEPSY ASSESSMENT FORM

Instructions: This form is required for all individuals with epilepsy or history of one or more seizures and must be provided at the time of the initial or periodic medical evaluation. Failure to provide this form may result in disqualification or delays in the evaluation process. This form should be completed by the medical provider/clinician who manages the driver's epilepsy or seizure disorder or for historical seizure(s), serves as the driver's treating or primary care clinician/provider.

Section I: Driver Information

Name *(Last, First, MI)*	Date of Birth (*mm-dd-yyyy*)

Section II: Seizure History

HISTORY

Single Seizure Only?	Epilepsy, or seizure disorder?
☐ Yes ☐ No	☐ Yes ☐ No
If yes, proceed to SINGLE SEIZURE	*If yes, proceed to EPILEPSY/SEIZURE DISORDER*

SINGLE SEIZURE

When was the single seizure (enter approximate date (*mm-yyyy*))? _____

Was the seizure provoked (i.e., there was a reason for the seizure)? ☐ Yes ☐ No	If "Yes", reason for seizure	If "Yes", risk factors for occurrence

☐ Yes ☐ No Is the patient at increased risk for another seizure?

Does the individual have any medical conditions placing him/her at risk for another seizure? ☐ Yes ☐ No	If "Yes", describe

EPILEPSY/SEIZURE DISORDER

List type of seizure disorder: _____

Is the individual currently on medication for epilepsy/ seizure disorder? ☐ Yes ☐ No		Name of Medication	Dose	Length of Treatment
	IF YES:			
	IF NO:	Previous treatment		Previous treatment

When was the patients last seizure*(enter approximate date (mm-yyyy))*? _____

For how long has the individual been stable on his/her treatment plan (stable means consistent medication and dosage, regular follow up, etc.)? List length of time in months/years: _____

☐ Yes ☐ No Are the seizures well controlled by the current treatment?

RESTRICTIONS

Are there any local (host nation) restrictions related to seizures/epilepsy and professional driving? ☐ Yes ☐ No	If "Yes", provide details

Name of Examinee	DOB

COMMENTS

Section III: Provider/Clinician Recommendation

_____ (initial): I attest that I am the individual's treating or primary clinician with knowledge about past history of one or more seizures and any treatment regimen.

Based on my assessment above, performed on _____ (mm-dd-yyyy):

- ☐ The individual can safely drive, without restrictions.
- ☐ The individual can safely drive with the following restrictions/limitations: _____
- ☐ The individual should not drive at this time.

Name of Provider/Clinician	Signature of Provider/Clinician	Medical Credential/Specialty

Clinic Address/Post	Phone Number	Email

***Note**: even if the documentation indicates the individual can drive, this document will be reviewed as part of the overall driver medical evaluation and in accordance with the US Department of State Bureau of Medical Services Driver Medical Evaluation Policy.

Paperwork Reduction Act Statement

Releases or disclosures of confidential medical information are governed by the Privacy Act of 1974, as amended, 5 U.S.C. § 552a et seq., and the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 701 et seq.

Privacy Act Statement

AUTHORITIES: The information is sought pursuant to 5 CFR 930.108, 339.301 and the Foreign Service Act of 1980, as amended (Title 22 U.S.C. 4084, 3901, and 3984).

PURPOSE: The information requested on this form will be used to determine medical eligibility for issuance of a driver medical certificate.

ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. The information may also be made available to local Health Units. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records

DISCLOSURE: Providing this information is voluntary; however, failure to provide this information may result in denial of a driver medical certification.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

To the individual and/or health care provider completing the medical history review /exam: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.