



U.S. Department of State
Bureau of Medical Services

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

USDH DRIVER MEDICAL EVALUATION FORM

Instructions: To the provider (physician, physician assistant, nurse practitioner) completing this - please review the Driver Medical Evaluation Policy documents. This can only be completed by a provider or medical authority from a federal agency.

Demographic and Employment Information

Name (Last, First, MI)

Date of Birth (mm-dd-yyyy)

Evaluation Date (mm-dd-yyyy)

Provider/Clinician Recommendation

_____ (initial): I have reviewed the employee's medical records and/or conducted a medical evaluation.

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

- ☐ The candidate can safely drive, without restrictions for 4 years.
- ☐ With corrective lenses (check, if applicable)
- ☐ With hearing aids (check, if applicable)
- ☐ The candidate is permitted to drive for _____ (length of time), due to _____.
- Recommend re-evaluation once _____ has been adequately managed for a duration of _____ (months/years) or stability has been documented by treating provider.
- ☐ The candidate is not permitted to drive for _____ (length of time), due to _____.
- Recommend re-evaluation once _____ has been adequately managed for a duration of _____ (months/years) or stability has been documented by treating provider.
- ☐ The candidate is not permitted to drive.
- ☐ More information needed: _____

Name of Provider/Clinician

Signature of Provider/Clinician

Medical Credential/Specialty

Clinic Address/Post

Phone Number

Email

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.