DL-13 (5-22)

pennsylvania
DEPARTMENT OF TRANSPORTATION

INITIAL REPORTING FORM

PLEASE TYPE OR PRINT ALL INFORMATION IN BLUE OR BLACK INK

Bureau of Driver Licensing • P.O. Box 68682 • Harrisburg, PA 17106-8682 • (717) 787-9662
Return this form to the address listed above, FAX to (717) 705-4415, or email to Medical@pa.gov.

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD

FOR OFFICIAL PENNDOT USE ONLY

PROVIDER: For more information relating to Medical Reporting, visit www.dmv.pa.gov and click on the Medical Reporting tab

SECTION A PATIENT INFORMATION

DRIVER'S LICENSE NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	SOCIAL SECURITY NUMBER
FEET	INCHES			MONTH	DAY	YEAR		

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.	CITY	STATE	ZIP CODE

DATE OF EXAMINATION: _____

How long have you been treating the patient? _____

SECTION B

DIAGNOSIS OF DISORDER OR DISABILITY: *Please Check (✔) Appropriate Items*

- ❑ Loss or Impairment of a Foot, Leg, Finger, Thumb, or Hand - Condition: _____
- ❑ Diabetes Mellitus
- ❑ Cerebral Vascular Disease
- ❑ Cardiovascular Disease
- ❑ Loss of Consciousness - Cause: _____
- ❑ Neurological Disorder
- ❑ Neuromuscular Disorder: _____
- ❑ Single Seizure: Date of Seizure: _____
- ❑ Seizure Disorder: ❑ YES ❑ NO Date of Last Seizure: _____
- ❑ Cognitive impairment: _____
- ❑ Neuropsychiatric Disorder: _____
- ❑ Psychiatric Disorder: _____
- ❑ Vision Deficiency: ❑ Acuity ❑ Visual Fields
- ❑ Other Medical Condition that would interfere with the patient's ability to drive. Explain: _____
- ❑ Sleep Apnea: _____
- ❑ Alcohol Use: _____
- ❑ Drug or Controlled Substance Use: _____

NOTE: A **seizure** disorder- More than one seizure or a single seizure of electrically diagnosed epilepsy.

Patient meets following seizure waiver, therefore no action should be taken on the driving privilege:

- ❑ 2 year history of strictly a nocturnal pattern of seizures or a pattern of seizures occurring only immediately upon awakening
- ❑ 2 year history of a specific prolonged aura accompanied by sufficient warning
- ❑ Patient has been seizure free for the previous 6 months and above referenced seizure occurred as a result of a prescribed change in or removal from medication. Patient's previous medication has been reinstituted.
- ❑ Patient has been seizure free for previous 6 months and above referenced seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance.

Should this individual cease driving immediately? . . . . . ❑ YES ❑ NO

If not, does the condition(s) warrant further investigation of driving competency by the Department? . . . . . ❑ YES ❑ NO

SECTION C

ALL INFORMATION IS CONFIDENTIAL AS PROVIDED IN THE PA VEHICLE CODE, SECTION 1518(d)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**

TELEPHONE NUMBER	FAX NUMBER

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ Health Care Provider's Signature

_____ Date