



Driver's Name _____
 (please print) (Last) (First) (Middle)

New Certification

Address _____
 (Number) (Street) (City) (State) (Zip)

Recertification

Date of Birth _____ Age _____

HEALTH HISTORY

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Head or spinal injuries	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cardiovascular disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Suffering from any other disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Gastro-intestinal ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, seizures, fits, convulsions, fainting	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease or injury	<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach
<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes				<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
			<input type="checkbox"/>	<input type="checkbox"/>	Polio				<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease

If answer to any of the above is yes, explain: _____

Driver's Signature _____

PHYSICAL EXAMINATION (when findings are normal, use check mark \checkmark only)

General appearance and development: Good _____ Fair _____ Poor _____ Height _____ Weight _____

Vision: Far distance: Right: 20/ _____ Left: 20/ _____ Without corrective lenses With corrective lenses if worn

Evidence of disease or injury: Right _____ Left _____ Color test _____

Horizontal field of vision: Right _____^o Left _____^o

Hearing: Right ear _____ Left ear _____ Disease or injury _____

Thyroid _____

Nose _____ Teeth _____ Throat _____

Thorax: Heart: Abnormalities _____ Regularity _____

Murmurs _____ If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____ Pulse _____

Lungs _____ Veins _____ Arteries _____

Abdomen: Liver _____ Kidney _____ Spleen _____

Hernia _____ External hemorrhoids _____

Spine: Curvature _____ Deformity _____

Limitation of motion _____

Extremities: Amputation, Deformity, Limitation: Upper _____ Lower _____

Remarks _____

Genito-urinary: Scars _____ Urethral discharge _____

Skin: _____

Nervous Stability: _____

Urinalysis: SP. GR. _____ Reaction _____ Albumen _____ Sugar _____

Correctable impairments: _____

Non-correctable impairments: _____

General comments: _____

MEDICAL EXAMINER'S CERTIFICATE

MUST BE SIGNED BY A LICENSED M.D., D.O. or D.C. - **NURSE, EMT, OR MEDICAL STUDENT SIGNATURES ARE NOT ACCEPTABLE**

I certify that I have examined _____, and with knowledge of his duties, I find him qualified to operate a taxicab, livery or sightseeing vehicle.

Qualified only when wearing corrective lenses

Qualified only when wearing a hearing aid

Date of Physical Examination _____ Telephone No. _____

Printed Name of Physician _____
 First MI Last Signature

Physician's Street Address _____ City _____ State _____ Zip Code _____