

MEDICAL CERTIFICATE

in connection with an application for/extension of a driving licence, tractor licence or taxi driver licence

<p>A. Current driving licence</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; padding: 2px; text-align: center;"> <small>Group I</small> <input type="checkbox"/> A <input type="checkbox"/> A1 <input type="checkbox"/> B <input type="checkbox"/> BE <input type="checkbox"/> Tractor </td> <td style="border: 1px solid black; padding: 2px; text-align: center;"> <small>Group II</small> <input type="checkbox"/> C <input type="checkbox"/> CE </td> <td style="border: 1px solid black; padding: 2px; text-align: center;"> <small>Group III</small> <input type="checkbox"/> D <input type="checkbox"/> DE <input type="checkbox"/> Taxi </td> </tr> </table> <p>Application for</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; padding: 2px; text-align: center;"> <small>Group I</small> <input type="checkbox"/> A <input type="checkbox"/> A1 <input type="checkbox"/> B <input type="checkbox"/> BE <input type="checkbox"/> Tractor </td> <td style="border: 1px solid black; padding: 2px; text-align: center;"> <small>Group II</small> <input type="checkbox"/> C <input type="checkbox"/> CE </td> <td style="border: 1px solid black; padding: 2px; text-align: center;"> <small>Group III</small> <input type="checkbox"/> D <input type="checkbox"/> DE <input type="checkbox"/> Taxi </td> </tr> </table> <p><small>A=heavy motorcycle, A1=light motorcycle, B=private car, C=heavy lorry, D=bus, E=heavy trailer, Tractor=tractor licence, Taxi=taxi driver licence</small></p>	<small>Group I</small> <input type="checkbox"/> A <input type="checkbox"/> A1 <input type="checkbox"/> B <input type="checkbox"/> BE <input type="checkbox"/> Tractor	<small>Group II</small> <input type="checkbox"/> C <input type="checkbox"/> CE	<small>Group III</small> <input type="checkbox"/> D <input type="checkbox"/> DE <input type="checkbox"/> Taxi	<small>Group I</small> <input type="checkbox"/> A <input type="checkbox"/> A1 <input type="checkbox"/> B <input type="checkbox"/> BE <input type="checkbox"/> Tractor	<small>Group II</small> <input type="checkbox"/> C <input type="checkbox"/> CE	<small>Group III</small> <input type="checkbox"/> D <input type="checkbox"/> DE <input type="checkbox"/> Taxi	<p>B. Personal particulars</p> <p>Social security number: _____</p> <p>Name : _____</p> <p>Address: _____ _____</p> <p>Telephone: _____</p> <p>Proof of identity: Known personally <input type="checkbox"/> ID card <input type="checkbox"/> Driving licence <input type="checkbox"/> </p>
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C. Declaration of health - questions to be answered in connection with the physician's examination

1. Do you have any illness, injury or other medical condition that could affect your ability to drive a motor vehicle? Yes No
2. Do you have any sight defect, such as
 - a) reduced visual acuity Yes No
 - b) involuntary eye movements (nystagmus) Yes No
 - c) field of vision defects (such as limited peripheral vision) Yes No
 - d) double vision Yes No
 - e) night blindness (tangibly worse vision in the dark)..... Yes No
 - f) impaired eye mobility..... Yes No
 - g) other visual disorder..... Yes No
3. a) Do you have / have you ever had sudden attacks of dizziness or vertigo?..... Yes No
 b) Do you have any serious hearing impairment?..... Yes No
4. Do you have any disease of / reduced locomotor functions?..... Yes No
5. Do you have / have you ever had any cardiovascular disease, such as Yes No
 - a) stroke (cerebral haemorrhage, thrombus in the brain)..... Yes No
 - b) vascular spasm..... Yes No
 - c) cardiac infarction..... Yes No
 - d) heart rhythm disorder..... Yes No
 - e) reduced heart valve functioning (heart murmur)..... Yes No
 - f) other cardiovascular disease..... Yes No
6. Do you have diabetes?..... Yes No
7. a) Do you have / have you ever had any neurological disease?..... Yes No
 b) Have you ever had a brain concussion with resulting loss of consciousness?..... Yes No
8. a) Do you have / have you ever had epilepsy?..... Yes No
 b) Do you have / have you ever had convulsions, fainting-fits or other consciousness disorders?..... Yes No

9. Do you have / have you ever had any seriously reduced kidney functioning? Yes No
10. Have you ever been bothered by lapses of attention, thinking ability or memory?..... Yes No
11. a) Do you have snoring problems causing restless sleep and tiredness during the day? Yes No
 b) Are you often afflicted by involuntary attacks of falling asleep? Yes No
12. Are you or have you ever been an abuser of alcohol, drugs or medicine? Yes No
13. Do you have / have you ever had any mental disorder/disease, e.g. schizophrenia or other psychotic syndromes, manic-depression or been diagnosed with ADHD, DAMP, Aspergers syndrome, or the like? Yes No

D.

1. Have you been hospitalised or contacted a physician as a result of the above (points C 1-13)? Yes No
 When? _____
 Name of hospital or clinic(s) _____

2. Are you currently being treated with any hypnotic or sedative drug or under any other long-term medication for any of the above diseases (points C 1-13)? Yes No
 If the answer is yes, which medicine(s)? _____

3. Have you ever before been examined by a physician in connection with an application for a learners permit? Yes No
 If the answer is yes, when? _____

4. Do you consider yourself completely healthy at the present time?..... Yes No
 If the answer is no, state why: _____

I hereby certify that the information I have given is completely true.

.....
 Place and date

.....
 Signature

E. Questions to be answered by physician

The physician should observe the Swedish National Road Administration provisions on the medical requirements for possession of a driving licence, tractor licence and taxi driver licence (VVFS 1996:200, amended by VVFS 1998:89). The certificate shall be issued according to the provisions in Ch 15.

1. What proof of identity did the applicant provide?

Known personally ID card Driving licence

2. Vision

a) Is there any sign of field of vision defects in connection with the Donders examination?..... Yes No
(In the event of any medical history details or findings that would motivate a closer examination, like the Goldmann examination or computed perimetry, the results of these shall be attached).

b) Is there any reduced eye mobility? (the test shall be conducted in all eight main meridians)..... Yes No

c) Does any double vision result when testing eye mobility? Yes No

d) Is there any nystagmus? Yes No

e) Is there any medical history of limited vision in connection with reduced lighting?..... Yes No

f) Does the person being examined have any kind of progressive eye disease?..... Yes No

g) Visual acuity (where all the letters in the row specifying the visual acuity must be correctly identified)

	without correction*	with correction**	corrective glass**	contact lenses
Right eye	_____	_____	_____	<input type="checkbox"/>
Left eye	_____	_____	_____	<input type="checkbox"/>
Binocular	_____	_____		

*) Compulsory information.

***) Compulsory information if the visual acuity required is only attained through correction.

NB! The information in 2 g) can be based on a written statement from a certified optician.

3. Hearing

a) Does the patient have any difficulty in understanding a normal tone of voice at a distance of four metres? (the use of a hearing aid is permitted) Yes No

If the answer is yes, specify the cause of the hearing impairment:

4. Locomotor functions

a) Does the patient have any disease of / reduced locomotor functions that could mean his or her not being able to drive a vehicle safely in traffic? Yes No

b) Is the patient's locomotory ability insufficient to be able to assist passengers in and out of a vehicle or with a seat belt (refers to Group III)? Yes No

5. Cardiovascular

a) Is there any cardiovascular disease that could entail a serious risk of acutely reduced brain functioning or that could otherwise jeopardise road safety? Yes No

b) Are there any important risk factors related to stroke (e.g. previous stroke or TIA, high blood pressure, atrial fibrillation or vascular deformity)? Yes No

c) Is there any sign of brain damage after trauma, stroke or other disease of the central nerve system?..... Yes No

6. Diabetes

Does the patient have diabetes? Yes No

If the answer is yes, specify the treatment: Diet Pills Insulin

7. Neurological diseases

Is there any sign of neurological disease? Yes No

8. Epilepsy and other consciousness disturbance

Does the patient have / has he or she ever had epilepsy or experienced any other consciousness disturbance? Yes No

9. Renal disorders

Is there any seriously reduced kidney functioning that could jeopardise road safety? Yes No

10. Dementia and other cognitive disturbances

Is there any sign of failing cognitive functioning? Yes No

11. Alertness disorders

Is there any sign of, or medical history that would indicate, an alertness disorder? Yes No

12. Alcohol and drugs

Is there any sign of, medical history or laboratory test results that would indicate the use of substances that affect the ability to drive a motor vehicle? Yes No

13. Mental disease

Does the patient have / has he or she ever had a mental disorder/disease, like schizophrenia or other psychotic syndrome, manic-depression or been diagnosed with ADHD, DAMP Aspergers syndrome, etc? Yes No

If the answer to any of the above questions is yes, it is required that the patient be referred for further examination as provided in VVFS 1996:200 (amended by VVFS 1998:89) Ch. 18 Section 3.

Comments (refers to sections C, D and E):

F. Assessment

The patient's health fulfils the requirements according to VVFS 1996:200 (a mended by VVFS 1998:89) for:

Group I				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A	A I	B	BE	Tractor

Group II	
<input type="checkbox"/>	<input type="checkbox"/>
C	CE

Group III		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D	DE	Taxi

unable to make a decision

Prior to making a final decision in this case, the patient should be examined by a medical specialist in:

Reappraisal of possession should take place within _____ months _____ years

.....
Place and date

.....
Physician's signature

.....
Address and telephone

.....
Block letters