

CERTIFICATE OF FITNESS - HEAVY VEHICLE DRIVERS/ COMMERCIAL VEHICLE DRIVERS

MR713 06/25

**Driver's Licence No:/
Driver Accreditation No:**

Class of Licence:

Class of Accreditation:

Due Date:

SECTION 1: YOUR DETAILS (to be completed in BLOCK letters prior to seeing your doctor)

APPLICANT'S DECLARATION

Surname_____

Given names_____

Home address_____

Suburb/Town_____ Postcode_____ Phone (B/Hr)_____

Postal address if different from above_____

Email address (if available)_____

I declare that to the best of my knowledge the information regarding my medical background is true and correct and that I have made the examining medical practitioner aware of any medical condition that I have and drugs or medication that I use.

I consent to my medical practitioner and/or treating specialist releasing to the Department for Infrastructure and Transport any medical information relating to my ability to drive safely.

Signature_____

A person must not, in providing information, make a statement that is false or misleading. Penalties apply.

Please note: Your medical practitioner has a legal obligation to inform the Registrar if they believe that a person they have examined is suffering from a medical condition such that they may endanger the public if they drove.

IMPORTANT NOTES FOR THE MEDICAL PRACTITIONER

The Registrar of Motor Vehicles requires certain applicants for a driver's licence, or licence holders, to provide evidence of their fitness to drive. Additionally, an applicant for driver accreditation under the *Passenger Transport Act 1994* is required to satisfy the Department of Planning, Transport and Infrastructure that they do not suffer any physical or mental incapacity that would impair their ability to work effectively as the driver of a public passenger vehicle and handle passengers. Please:

- Review section 2: Patient Questionnaire with the person;
- Refer to the National Transport Commission's "Assessing Fitness to Drive" guidelines - commercial standards for heavy vehicle licence or public passenger vehicle drivers. The guidelines are available from Austroads at www.austroads.com.au (your assessment must be undertaken in accordance with the guidelines);
- Complete all of sections 3 and 5;
- Please complete section 4 if your patient has a vision or eye disorder, or is required to wear glasses or corrective lenses;
- Provide comment in the notes section on page 3 on how well controlled your patient's condition(s) are and compliance with any medication taking.

WHAT TO DO WITH THE COMPLETED MEDICAL ASSESSMENT

Return to GPO Box 1533, Adelaide 5001 or any Service SA Customer Service Centre.
Enquiries: 13 10 84

When complete -
OFFICIAL: Sensitive//Medical in confidence

SECTION 2: PATIENT QUESTIONNAIRE (to be completed by patient prior to medical examination)



Please answer the questions by ticking the correct box. If you are not sure, leave the question blank and ask your medical practitioner what it means. They will ask you additional questions during the examination.

[illegible]

SECTION 3: EXAMINATION REPORT

1. BLACKOUT

Has the patient experienced a blackout? ☐ No ☐ Yes

If Yes, please complete the following.

Date of most recent episode: ____/____/____

2. CARDIOVASCULAR CONDITION

Does the patient have a cardiovascular condition or has the patient undergone a cardiovascular procedure? ☐ No ☐ Yes

If Yes, please tick the relevant condition(s):

- ☐ Acute Myocardial Infarction (AMI)
- ☐ Dilated Cardiomyopathy
- ☐ Angina (If Unstable)
- ☐ Heart Failure
- ☐ Atrial Fibrillation (AF)
- ☐ Heart Transplant
- ☐ Cardiac Aneurysm
- ☐ Hypertrophic Cardiomyopathy
- ☐ Cardiac Arrest
- ☐ Implantable Cardioverter Defibrillator (ICD)
- ☐ Cardiac Pacemaker
- ☐ LVAD/BIVAD
- ☐ Congenital Heart Disorder
- ☐ Percutaneous Coronary Intervention (PCI or Angioplasty)
- ☐ Coronary Artery Bypass Grafting (CABG)
- ☐ Other (please specify):_____

(N.B if patient has an ICD implanted they may be eligible to hold a commercial class of licence, please refer to national guidelines.)

3. HYPERTENSION

Does the patient have blood pressure consistently greater than 170 systolic or greater than 100 diastolic (treated or untreated)? ☐ No ☐ Yes

Blood Pressure Readings

Systolic: _____ Diastolic: _____

4. DIABETES

Does the patient have diabetes controlled by medication? ☐ No ☐ Yes

If Yes, please complete the following.

Diabetes controlled by ☐ Insulin ☐ tablet: _____

Date of last severe hypoglycaemic episode if applicable: ____/____/____

5. HEARING LOSS

Does the patient have severe hearing loss? ☐ No ☐ Yes

6. MUSCULOSKELETAL CONDITION

Does the patient have a musculoskeletal condition? ☐ No ☐ Yes

If Yes, please tick the relevant condition(s):

- ☐ Severe Arthritis
- ☐ Limb
- ☐ Other Musculoskeletal Conditions (specify condition) _____

7. NEUROLOGICAL / NEUROMUSCULAR CONDITIONS

Does the patient have a neurological / neuromuscular condition? ☐ No ☐ Yes

If Yes, please tick the relevant condition(s):

- ☐ Brain Aneurysm
- ☐ Parkinson's Disease
- ☐ Cerebral Palsy
- ☐ Seizure
- ☐ Dementia
- ☐ Date of last episode: __ / __ / __
- ☐ Epilepsy
- ☐ Space-occupying Lesion (brain tumour)
- ☐ Date of last episode: __ / __ / __
- ☐ Head Injury
- ☐ Stroke
- ☐ Date of last episode: __ / __ / __
- ☐ Multiple Sclerosis
- ☐ Subarachnoid Haemorrhage
- ☐ Date of last episode: __ / __ / __
- ☐ Muscular Dystrophy
- ☐ Other (please specify) _____

8. PSYCHIATRIC CONDITION

Does the patient have a severe mental health/nervous condition? ☐ No ☐ Yes

If Yes, please tick the relevant condition(s):

- ☐ Bipolar Affective Disorder
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Chronic Anxiety
- ☐ Schizophrenia
- ☐ Chronic Depression
- ☐ Personality Disorder
- ☐ Other: _____

Does the patient require medication? ☐ No ☐ Yes

If Yes - is the patient compliant with medication? ☐ No ☐ Yes

9. SLEEP DISORDER

Does the patient have a sleep disorder? ☐ No ☐ Yes

If Yes, please complete the following.

Established Sleep Apnoea Syndrome ☐ No ☐ Yes

Narcolepsy ☐ No ☐ Yes

Other: _____ ☐ No ☐ Yes

10. SUBSTANCE MISUSE

Does the patient currently misuse/abuse alcohol or drugs? ☐ No ☐ Yes

If Yes, please complete the following.

Does the patient abuse alcohol? ☐ No ☐ Yes

Does the patient use illicit drugs? ☐ No ☐ Yes

Does the patient misuse prescription drugs? ☐ No ☐ Yes

SECTION 4: EYESIGHT CERTIFICATE

Only complete questions 11 and 12 if your patient has a vision or eye disorder, or is required to wear glasses or corrective lenses.

11. Does your patient have one or more of the following vision or eye disorders? Please tick:

- ☐ Diplopia
- ☐ Retinitis Pigmentosa
- ☐ Monocular Vision
- ☐ Visual Field Defect

Note: If any of the above is ticked, the eyesight certificate must be completed by an Optometrist or Ophthalmologist.

Does your patient have one or more of the following vision or eye disorders? Please tick:

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Other vision or eye disorder which may impair their ability to drive (please specify)

12. Visual acuity	Right	Left
Uncorrected	6/____	6/____
Corrected (glasses/contacts)	6/____	6/____

Note: The patient's visual acuity with corrective lenses in the better eye must be at least 6/9 and the worse eye at least 6/18. If the patient doesn't meet the standards, this section must be completed by an Optometrist or Ophthalmologist. (Refer to Vision and Eye disorders in "Assessing Fitness to Drive" publication.)

Does your patient meet the eyesight standards in the Assessing Fitness to Drive guidelines? ☐ No ☐ Yes

Are glasses or contact lenses required for driving? ☐ No ☐ Yes

Should a condition be placed on the licence? ☐ No ☐ Yes

(e.g. daylight hours only)

If Yes, please provide details below.

_____/_____/_____
Medical Practitioner name

Optometrist/Ophthalmologist name

_____/_____/_____
Date

Signature

Signature

Contact Number

ADDITIONAL NOTES: Provide comment to each ☒ Yes condition(s) below including reference to the specific condition (e.g. 4. Diabetes).

SECTION 5: MEDICAL PRACTITIONER’S DECLARATION

Under section 148 of the Motor Vehicles Act 1959 you have a legal obligation to inform the Registrar of Motor Vehicles if you have reasonable cause to believe that the patient is suffering from a physical or mental illness, disability or deficiency that is likely to endanger the public if the patient drives a motor vehicle.

If you consider it prudent or necessary you may recommend that the patient undertakes a practical driving assessment. This is irrespective of the patient’s age or driver’s licence class. Patients who hold a licence other than a "car" licence are required to undergo a practical driving assessment at age 85 and every year thereafter.

If you consider that your patient may be unfit to drive, please immediately return the completed certificate to

Locked Bag 700, GPO ADELAIDE SA 5001, or email dit.licenceservices@sa.gov.au

It is recommended that you keep a copy for your own records.

MEDICAL PRACTITIONER’S DECLARATION (to be completed by Medical Practitioner)

On: ____/____/____ I examined _____ ____/____/____
Date of Examination Patient’s Name Date of Birth

The patient has been treated at this clinic for _____ years _____ months.

In my opinion the person who is the subject of this report:

Meets the relevant medical standard No ☐ Yes ☐

If no, does the person meet the standards for a light vehicle licence? No ☐ Yes ☐

Requires a practical driving test by a Department for Infrastructure and Transport Examiner No ☐ Yes ☐

If a practical driving test is required please tick for which vehicle class type:

Heavy Vehicle ☐ Car ☐ Motorbike ☐ All Classes ☐

Do you recommend conditions be placed on the licence? No ☐ Yes ☐

Please provide further details on any of the above questions below:

☐ Further comments on medical condition(s) affecting safe driving are attached.

I certify that I personally examined the above named patient in accordance with the “Assessing Fitness to Drive” guidelines. If the applicant holds a driver accreditation, I have considered that they are medically and psychologically fit to drive a public passenger vehicle and handle passengers.

Medical Practitioner’s signature Date ____/____/____

Medical Practitioner’s name

Medical Practitioner’s practice address

Telephone Number Facsimile Number E-mail Address

Please complete if a specialist has assessed any of the patient’s conditions in addition to the treating medical practitioner (Not required if a separate report has been provided or a specialist has completed the declaration above).

Specialist name: _____

Type of specialist: _____

Conditions assessed: _____

Specialist’s signature: _____ Date: ____/____/____

If more than one specialist has undertaken an assessment, please provide your details in the comments section above or attach a report if applicable.