DL-122 (4-12)

DIABETIC FORM

PLEASE TYPE OR PRINT ALL INFORMATION IN BLUE OR BLACK INK

pennsylvania
DEPARTMENT OF TRANSPORTATION

Bureau of Driver Licensing
P.O. Box 68682
Harrisburg, PA 17106-8682
(717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12
Provider: For more information relating to Medical Reporting, visit http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml

PATIENT INFORMATION (Please complete this form in its entirety unless otherwise noted)

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

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE 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

1. How long have you been treating the patient? _____
2. Do you treat the patient on a regular basis? _____
3. Has the patient been diagnosed with diabetes mellitus? _____

PLEASE NOTE: IF PATIENT HAS BEEN DIAGNOSED WITH DIABETES, PAGE 2 OF THIS FORM MUST BE COMPLETED.

4. Has the patient been diagnosed with unstable diabetes mellitus? _____

   If yes, please continue. If no, you may move on to complete page 2.

   a. Within the past 6 months, has it led to severe hypoglycemic reaction(s) that required outside intervention or assistance of others or that produced confusion, loss of attention or a loss of consciousness? _____

      If yes, date of episode(s): _____

   b. Within the past 6 months, has it led to symptomatic hyperglycemia, which caused a loss of consciousness or an altered state of perception, including, but not limited to, decreased reaction time, impaired vision or hearing, or both, and confusion? _____ If yes, date of episode(s):_____

   c. If yes, did the episode(s) occur while under a health care provider's supervision? _____

   d. If yes, did the episode(s) occur during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance? _____

   e. If yes, was the episode(s) caused by a temporary condition or isolated incident that is not likely to recur? _____

5. Is the patient being treated with medication? _____

   If yes, type:_____ dosage: _____

6. What were the results of the patient's most recent HbA1C screening? _____ date of test : _____

HEALTH CARE PROVIDER INFORMATION (Please print or type)

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

Patient Name _____ Driver's License Number_____

REGULAR DRIVER (CLASS A, B, C & M)

UNCORRECTED
R 20/
L 20/
B 20/

CORRECTED
R 20/
L 20/
B 20/

1. Please indicate individual's visual acuity by marking the appropriate box:

❑ A. Combined vision is 20/40 or better. . . .With Correction ❑ W/O Correction ❑

❑ B. Combined vision is poorer than 20/40 but has been corrected to 20/60 or better.

❑ C. Combined vision is poorer than 20/60 but has been corrected to at least 20/70.

a) Do you consider this person visually capable to drive?. . . . Yes ❑ No ❑

❑ D. Combined vision is poorer than 20/70 and not correctable to 20/70.

	CHECK ONE: YES	NO
2. Is individual's combined field of vision at least 120° in the horizontal meridian, excepting the normal blind spots?	❑	❑
3. Does individual have better than 20/100 vision in each eye with correction?	❑	❑
4. Must individual wear corrective lenses?	❑	❑
5. Does this individual no longer require corrective lenses as a result of corrective surgery?	❑	❑
6. Is correction obtained through telescopic lenses?	❑	❑
7. Did this individual have a dilated eye exam?	❑	❑

Date of last dilated eye exam: _____

HEALTH CARE PROVIDER INFORMATION (Please print or type)

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