DL-126 (4-12)

ORTHOPEDIC FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

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)

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

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	E-MAIL (if applicable)
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 this patient? _____
2. Does the patient have a loss or impairment of a joint or extremity? _____

   If yes, please describe: _____
3. Has the patient been diagnosed with rheumatic, arthritic, orthopedic, muscular, vascular or neuromuscular disease? _____

   If yes, please describe: _____
4. Do any of the above condition(s) create a functional limitation that would impair his/her ability to operate a motor vehicle? _____

   If yes, please describe: _____
5. Has the patient been advised not to drive due to the functional impairment? _____
6. Will the impairment last longer than 90 days? _____
7. Is the patient being treated with medication? . . . . . ❑ YES ❑ NO

   a. If yes, does the medication make him/her an unsafe driver? . . . . . ❑ YES ❑ NO

   b. If no, how is this condition(s) being addressed? _____

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