



## Physician's Certificate for Vehicle Operator

(This must be filled out by a physician)

Named insured: \_\_\_\_\_ Policy number: \_\_\_\_\_

Name of vehicle operator: \_\_\_\_\_ Age: \_\_\_\_\_

Address of vehicle operator: \_\_\_\_\_

Has the vehicle operator had any loss or reduction of vision or hearing that would impair driving? If yes, please explain below.  Yes  No

To your knowledge, has the vehicle operator ever suffered from any of the following? If yes, when?

- Convulsions:  Yes  No \_\_\_\_\_
- Attacks of unconsciousness:  Yes  No \_\_\_\_\_
- Dizzy spells:  Yes  No \_\_\_\_\_
- Diabetes:  Yes  No \_\_\_\_\_
- Epilepsy:  Yes  No \_\_\_\_\_
- Heart attacks:  Yes  No \_\_\_\_\_
- Chronic illness:  Yes  No \_\_\_\_\_

Does the vehicle operator have any stiffness or arthritis to the extent that it interferes with the use of upper and lower extremities?  Yes  No

Are the vehicle operator's reflexes normal?  Yes  No

Average blood pressure reading: \_\_\_\_\_

Is the vehicle operator currently or in the past enrolled in any Alcohol or Drug rehabilitation program:  Yes  No

Does driver's license have physical restrictions? If yes, please explain: \_\_\_\_\_

Are you aware of any other physical or mental conditions that would impair the vehicle operator's ability to operate a motor vehicle?  Yes  No

If yes, please explain: \_\_\_\_\_

The following questions are to be completed by the physician after talking to the vehicle operator and observing the reactions.

What is your impression the vehicle operator's general physical and mental condition with respect to the ability to drive an automobile? \_\_\_\_\_

Additional comments: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of vehicle operator, authorizing the release of this medical report to Brotherhood Mutual:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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