OVR 14A

(rev. 01/2024)

Kentucky Office of Vocational Rehabilitation Driver Rehabilitation Program Physician's Consent

Kentucky Career Center
Vocational Rehabilitation

Note: *The below-named individual has requested to participate in a driver evaluation, driver training and/or vehicle modification program. The evaluation will be conducted by a Certified Driver Rehabilitation Specialist (CDRS). The Physician's Consent is NOT the final determining factor for the person to have a driver's license. The final decision will be made from the recommendation of the Certified Driver Rehabilitation Specialist (CDRS) and by the Division of Driver License.*

1. Patient Information

Name	**SSN** *(last 4-digits)*	**Date of Birth**
Address		
City	**State**	**Zip Code**
Occupation		

2. Medical History

If hospitalized in the past two years, give reason(s), date(s) and discharge diagnosis
Referring Diagnosis
Has the patient ever been diagnosed with any of the following conditions? *If yes, please explain*
☐ Alcohol or Drug Abuse Problems _____
☐ Cerebrovascular Disorder _____
☐ Musculoskeletal Disorder _____
☐ Peripheral Vascular Disorder _____

☐ Respiratory Disorder	
☐ Cardiovascular Disorder	
☐ Diabetes or other Endocrine Disorder	
☐ Neurological or Neuromuscular Disorder	
☐ Psychosocial, Emotional, or Mental Disorder	
☐ Visual or Hearing Impairment	

Other diagnosis not listed above *(Please describe)*

Medications

Has the patient ever had a seizure?	**If yes, date of last seizure**

3. Physician Information

Physician Name		
Address		
City	**State**	**Zip Code**

Based on my examination, the patient named above is medically fit to take part in a Driver Rehabilitation Program evaluation.
Comments

Physician's Signature

Date (MM/DD/YYYY)