

APPLICANT TO COMPLETE THIS PAGE

If you already have a New Zealand driver licence, what is the licence number?

Reason for medical certificate

I am seeking a medical certificate to support an application for:

- ☐ A driver licence ☐ Renewal of my driver licence ☐ Comply with licence condition
☐ An endorsement ☐ Renewal of my endorsement
☐ A new licence class ☐ Renewal of my driver licence (at 75 years or over)

Licence Class(es)

- ☐ Class 1 ☐ Class 6
☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ Class 5

Endorsement type

- ☐ D ☐ F ☐ R ☐ T ☐ W
☐ Passenger ☐ Vehicle Recovery ☐ Driving Instructor ☐ Testing Officer

Details of applicant

Surname or family name

Full first names

Date of birth

 / /
Day Month Year

Physical address

Mailing address

Contact telephone numbers

Home ()	Work ()
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Giving your telephone number(s) is optional

Important information for applicant

You should note that the Land Transport (Driver Licensing) Rule 1999 requires the collection of the information you provide on this form, in order to determine your medical fitness to drive. The information is collected and held by the NZ Transport Agency (NZTA). You are entitled to access, and request the correction of, any easily retrievable information about you held by the NZTA.

Information relating to driver licence status, but not your medical certificate or any details of any medical conditions that you may have, may be released under the Land Transport Act 1998.

It is an offence to supply false information and may lead to your application being delayed or declined.

Applicant's statement

I have presented myself to the doctor named on this certificate for examination for fitness to drive. I undertake to provide truthful answers to the best of my knowledge to the doctor's questions related to my health, without knowingly withholding information.

I consent to the doctor informing the NZTA of the opinion reached regarding my fitness to safely drive a vehicle, and consent to the release to the NZTA of any medical records relating to this application if necessary.

Signature of applicant

Date

 / /
Day Month Year

THIS CERTIFICATE IS VALID FOR 60 DAYS FROM THE DATE THE DOCTOR ISSUES IT

DOCTOR TO COMPLETE THIS PAGE

DOCTOR TO COMPLETE EYESIGHT SECTION FIRST - TOP OF PAGE 4

IMPORTANT: Practitioners are reminded that the guidelines outlined in *Medical aspects of fitness to drive* only apply where a patient's medical condition affects or may affect their ability to drive safely. Particular attention should be paid to applicants or holders of commercial licence classes.

Hearing

For passenger, vehicle recovery, driving instructor or testing officer endorsements only

Ordinary conversation at 3 metres?
(with hearing aid if necessary)

☐ Yes ☐ No

Medical History

Please refer to Medical aspects of fitness to drive guidelines

Are you the applicant's usual doctor?

☐ Yes ☐ No

How long have you treated the patient/how long has the patient attended this medical practice?

Do you know the medical history of the patient?

☐ Yes ☐ No

Please indicate 'yes' or 'no' if your patient has any of the conditions listed below. If yes, please provide copies of any relevant specialist reports and/or provide sufficient detail in the 'Comments' section on page 3 to demonstrate or confirm the degree of control.		Is this medical condition likely to affect, or does it raise concerns about, their ability to safely control a motor vehicle?
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	PLEASE TICK ALL BOXES THAT APPLY <input type="checkbox"/> Type 1 (Specialist reports required for commercial class) <input type="checkbox"/> Type 2 <input type="checkbox"/> Insulin <input type="checkbox"/> Oral agents <input type="checkbox"/> Diet controlled If yes, please provide copies of any relevant specialist reports and/or provide sufficient detail in the comments section to demonstrate or confirm the degree of control.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular conditions <input type="checkbox"/> Yes <input type="checkbox"/> No	(excluding controlled hypertension) If yes, refer to comments section (reports required) Please specify: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular/skeletal disorder/Locomotor conditions <input type="checkbox"/> Yes <input type="checkbox"/> No	eg. limb loss, paralysis, arthritis. Please specify: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological and related conditions <input type="checkbox"/> Yes <input type="checkbox"/> No	eg. Cerebrovascular Accident, Multiple Sclerosis, Parkinson's Disease, Transient Ischaemic Attacks, Alzheimer's Disease, dementia, head injury etc. Please specify: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual problems <input type="checkbox"/> Yes <input type="checkbox"/> No	eg. cataracts, glaucoma, visual acuity less than 6/12, field deficits <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medications <input type="checkbox"/> Yes <input type="checkbox"/> No	The applicant is on medication which may affect their ability to drive. (Details of medications to be recorded in comments section)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	eg. Obstructive Sleep Apnoea, respiratory, syncope and/or vestibular disorders, dizziness, metabolic/endocrine. Please specify: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/seizures or blackout <input type="checkbox"/> Yes <input type="checkbox"/> No	Refer to Medical aspects of fitness to drive section 2 for reference to commercial licence holders. DATE OF LAST ATTACK/EVENT: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

☐ Yes ☐ No

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☐ Yes ☐ No

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COMMENTS
Please provide copies of any relevant reports (specialist reports if applicable) that are available, including final diagnosis and current treatment/medication and likely side effects. Indicate how the patient's driving ability may be affected by the medical condition. Indicate if condition has been stable.

This image shows a single page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Legal information for doctors

Principle 11 of the Privacy Act 1993 allows for personal information to be disclosed where this is necessary "to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution and punishment of offences". The NZTA is a public sector agency.

Section 18 of the Land Transport Act 1998 requires medical practitioners to provide information about their patients if they consider that their patient should not drive, or should only drive subject to limitations, and is likely to continue to drive a motor vehicle contrary to doctor's advice. In these circumstances the provisions of the Privacy Act that protect such information from disclosure do not apply and the practitioner concerned who gives such notice in good faith is not liable for any civil or professional liability because of any disclosure of personal medical information in that notice.

NOTE TO DOCTOR - Any specialist reports may be stapled inside this form. To protect medical information, this page and the opposite one can be sealed together by removing the tape and folding closed.

Eyesight

If special circumstances exist the applicant may apply to the medical section for an exemption from meeting the eyesight requirements.

Classes 1-6*
Endo FRTWD

With correcting lenses

Both

Without correcting lenses

Both

at least 6/12

* At least 6/12 using both eyes, or using one eye if monocular vision.

Classes 2-5**
Endo PVIO

With correcting lenses

Left

Right

Both

Without correcting lenses

Left

Right

Both

at least 6/18

at least 6/18

at least 6/9

** Each eye must be tested separately and then both eyes together. If the applicant does not meet the standards for an individual eye, then they may have monocular vision. Please refer to section 6.5 Monocular vision in the Medical aspects of fitness to drive.

Peripheral vision (Peripheral vision standard is 140° for all classes)

☐

Normal

☐

Reduced

(If reduced refer the applicant to an optometrist or ophthalmologist. Please note that the applicant cannot be recommended as fit to drive if they have reduced peripheral vision below 140°)

Summary

TICK the appropriate box and CROSS OUT the statements that don't apply

Having regard to *Medical aspects of fitness to drive* and knowledge of the medical details of the applicant I am of the opinion that the applicant is:

1. Medically fit to drive classes:

☐

1, 6, D, F, R, T, W

☐

1, 2, 3, 4, 5, 6, D, F, R, T, W, P, V, I, O

2. Medically fit to drive the following classes with the following recommendations (A and/or B):

☐

1, 6, D, F, R, T, W

A. ☐ Fit to drive safely with the following conditions:

B. ☐ I recommend that the applicant undertakes an on-road safety test with a testing officer to ascertain whether they meet the minimum standards of safe driving. (The NZTA will enforce this recommendation).
NB: The applicant is medically fit to undertake an on-road driving test and is over the age of 74 years.

3. In need of further assessment as follows (A and/or B):

☐

1, 6, D, F, R, T, W

☐

2, 3, 4, 5, P, V, I, O

A. Requires further medical assessment to determine capacity to drive safely

☐

I have referred to specialist for assessment

Specify assessment required:

B. Requires occupational therapy assessment of driving

☐

I have referred for occupational therapy driving assessment in class(es)

4. NOT medically fit for classes:

☐

1, 6, D, F, R, T, W

☐

2, 3, 4, 5, P, V, I, O

If the patient is not medically fit for class 1 or 6, please ensure advice is sent to the NZ Transport Agency, Medical Section, Private Bag 11777, Palmerston North 4442 (phone 0800 822 422 ext 8089, fax 06 953 6261)

Medical examination

(A FULL medical examination includes chest/lungs, cardiovascular system, abdomen, neurological and locomotor system and cognitive skills have also been tested)

☐

A full medical examination

☐

A partial medical examination

Verification stamp and/or Doctor's name, address & phone number (print clearly)

Dated

Signature of Doctor