New Nouveau Brunswick

Medical fitness report

Department of Justice and Public Safety
Motor Vehicle Branch
P. O. Box 6000 Fredericton, NB E3B 5H1

* Fee for examination is the responsibility of the licence applicant.
This form is to be completed by a licensed medical or nurse practitioner. A positive response must be elaborated upon at the bottom of the form. The physician's or clinic's stamp must be affixed in the space provided.

Name of Applicant ______________________ Date of Birth ______________

Address ____

Licence Number ______________________ Class of licence applied for ______________

Does the patient have a history or diagnosis of any of the following:

1. Any loss or impairment of limbs or extremities or other structural defect, limitation of mobility or co-ordination likely to interfere with the safe operation of a motor vehicle? ☐ Yes ☐ No
2. Any impairment of the musculo-skeletal or nervous system likely to interfere with the safe operation of a motor vehicle? ☐ Yes ☐ No
3. Diabetes mellitus which requires either insulin or oral agents for control? ☐ Yes ☐ No
4. Myocardial infarction, angina pectoris, coronary insufficiency or thrombosis? ☐ Yes ☐ No
   If first incidence, is the patient fully recovered? ☐ Yes ☐ No
5. Heart or lung disease including arrhythmia or respiratory dysfunction? ☐ Yes ☐ No
6. Hypertension accompanied by postural hypotension resulting in giddiness when under treatment? ☐ Yes ☐ No
7. Requirement for hearing assistance? ☐ Yes ☐ No
8. Loss of consciousness or awareness due to a chronic or recurring condition? ☐ Yes ☐ No
9. Continuous use of any prescribed drug which could, in the dosage prescribed, impair ability to operate a motor vehicle? ☐ Yes ☐ No
10. Clinical diagnosis of alcoholism or drug addiction? ☐ Yes ☐ No
11. Established medical evidence of a sustained psychiatric disorder with particular regard to depression, suicidal tendencies or impulsive aggressive behaviour? ☐ Yes ☐ No
12. Any other physical or mental impairment, disease or condition which is likely to significantly interfere with the individual's ability to operate a motor vehicle safely? ☐ Yes ☐ No

Driver examiner's use only

Vision screening

☐ Without lenses ☐ With lenses

____
Examiner

Authorized training for class ______________

until ______________ DD/MM/YY

____
Examiner

Date ______________

Valid for N.B., P.E.I., N.S.

Office stamp

Question	Remarks

This is to certify that I examined the above named applicant on ______________ DD/MM/YY

and that this individual has been my patient since ______________ DD/MM/YY

Examining Physician or Nurse Practitioner (print) ______________________

Address ____

____
Signature (Examining Physician or Nurse Practitioner)

Physician's or Clinic's stamp