Government of **Western Australia**
Department of **Transport**

M108A

Medical Assessment Certificate
Senior Driver's Licence Renewal Declaration

Prior to the renewal of your driver's licence, you must take this form to your health professional who will conduct an assessment of your fitness to drive a motor vehicle. Read the detailed medical assessment instructions (M106A) for the applicant and health professional. This form may be submitted to the Department of Transport (DoT) via email to driverservices@transport.wa.gov.au, via Electronic Medical Assessment (enquire with your GP) or post to the Driver Services, Department of Transport, GPO Box R1290, PERTH WA 6844. Mark as Confidential.

Applicant details - to be completed by applicant or Department of Transport

FAMILY NAME	
GIVEN NAMES	DATE OF BIRTH
RESIDENTIAL ADDRESS	

Indicate the authorisations you are proposing to retain. Any authorisations not indicated will be surrendered. If you surrender an authorisation and wish to obtain it again in the future, you will be required to make an application, complete required assessments and pay the associated fees.

	PRIVATE STANDARD			COMMERCIAL STANDARD					
TYPE OF VEHICLE	MOTOR CAR	MOTORCYCLE	LIGHT RIGID	MEDIUM RIGID	HEAVY RIGID	HEAVY COMBINATION	MULTI COMBINATION	DRIVING INSTRUCTOR	PASSENGER TRANSPORT DRIVER (F OR T EXTENSION)
CLASS	C ☐	R ☐	LR ☐	MR ☐	HR ☐	HC ☐	MC ☐	DI ☐	PTD ☐

REASON FOR REFERRAL

DRIVER'S LICENCE / PERMIT NO:	EXPIRY DATE:
APPLICATION TYPE:	
APPLICANT SUFFERS FROM: **APPLICANT IS UNDER THE FOLLOWING TREATMENT/ MEDICATION:**	

DOT#22 07.04.2020

DRIVING HISTORY WITHIN THE LAST 3 YEARS

1. Have you been convicted of a traffic offence? (Including an Infringement Notice) ☐ Yes ☐ No

2. Have you been involved in a traffic crash? ☐ Yes ☐ No

If YES, which State/Town/Suburb? _____

MEDICAL QUESTIONS

Do you suffer from any medical condition that may affect your ability to drive a motor vehicle? Yes ☐ No ☐
If **Yes**, please give details and specify treatment where applicable

Medical condition: _____

Treatment/Medications: _____

I consent to any reporting health professional releasing information to DoT and DoT contacting any health professional to obtain further information which is relevant to my fitness to drive.

I certify that I have completed all relevant sections above and all information is true and correct.

Signature of applicant _____ Phone Number _____ Date _____

PLEASE NOTE: It is unlawful to provide false or misleading information. A penalty may be imposed.

Enquiries 13 11 56

ASSESSMENT OF FITNESS TO DRIVE (AFTD) COMPLETED BY HEALTH PROFESSIONAL

SECTION 1

Were you familiar with the patient's medical history prior to this examination?

☐ YES ☐ NO

SECTION 2

I have attended this patient professionally since:

(Month/Year)

Visual Acuity

☐ Uncorrected			☐ Corrected		
L	R	B	L	R	B
6/	6/	6/	6/	6/	6/

Blood Pressure Reading

Relevant AFTD Medical Condition/s

SECTION 3

Clinical Findings - Provide where applicable:

- details of AFTD medical condition/s
- treatments
- history of episodes
- details of control or complication/s
- conditions of licence
- results of relevant investigations e.g. Hba1c for diabetes

SECTION 4

In my opinion the person who is the subject of this report:

☐ **a) Fit to drive** - Meets the relevant medical criteria

☐ **b) Not fit to drive -** Does not meet the relevant medical criteria - (Detail relevant clinical findings at question 3)

☐ **c) Fit to drive with conditions - Is suitable to drive subject to conditions -** (Detail relevant clinical findings at question 3)

Note: A conditional licence will not be issued unless adequate supporting information is provided by the examining health professional to the relevant department.

ASSESSMENT OF FITNESS TO DRIVE (AFTD) COMPLETED BY HEALTH PROFESSIONAL CONT.

SECTION 5

Does this patient require specialist assessment for their suitability to drive?

☐ YES ☐ NO

IF YES, SPECIFY DETAILS

☐ **Occupational Therapist assessment** (may include driving assessment).

☐ **On-road practical driving assessment by the DoT**
By selecting this option you are confirming that the patient is fit to undertake an on-road practical driving assessment with a DoT driving assessor.

SECTION 6

Recommended re-assessment period.

YEARS

SECTION 7

I have discussed this recommendation with patient.

☐ YES ☐ NO

SECTION 8

I have examined the patient according to:

☐ **Commercial vehicle standards** - Heavy vehicle driver (class MR and above), dangerous goods vehicle driver, passenger transport driver and driving instructors must be examined at commercial vehicle standards.

OR

☐ **Private vehicle standards**

DECLARATION

DATE OF EXAMINATION

☐☐ / ☐☐ / ☐☐☐☐

NAME OF REPORTING PROFESSIONAL

QUALIFICATION OF REPORTING PROFESSIONAL

DATE OF REPORT

☐☐ / ☐☐ / ☐☐☐☐

SURGERY STAMP

I certify that I have examined the above-mentioned patient in accordance with the current, relevant National Medical Standards (private or commercial vehicle standards) as set out in the Austroads publication **Assessing Fitness to Drive**.

TELEPHONE

EMAIL ADDRESS

SIGNATURE

☐ Additional medical condition(s) affecting safe driving attached.