



**INSTRUCTIONS:**

1. This form is to be used by applicants who are seeking to travel via **INTRASTATE** only.  
(*Intrastate is defined as the operation of a commercial motor vehicle only within the boundaries of Connecticut*)
2. Part 1 is to be completed by the applicant.
3. Part 2 must be completed by a Medical Examiner (license physician, Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN)
4. The completion of this form must be based upon a personal examination that is completed **WITHIN THE PAST NINETY (90) DAYS**.
5. All parts of this form must be completed and submitted to [dmv.suspension@ct.gov](mailto:dmv.suspension@ct.gov) or to the mailing address listed above.
6. Incomplete forms will be returned to the applicant's mailing address.
7. Medical Reports may be referred to the Department of Motor Vehicle's Medical Advisory Board (MAB) for review.

**PART 1 - TO BE COMPLETED BY THE APPLICANT (Please Print)**

APPLICANT'S NAME ( LAST, FIRST, MI)	DATE OF BIRTH	TELEPHONE NUMBER (    )	LICENSE NUMBER
APPLICANT'S MAILING ADDRESS (HOUSE #, STREET NAME, APT #, CITY, STATE, ZIP			E-MAIL ADDRESS

The State of Connecticut Department of Motor Vehicles (DMV) may allow commercial motor vehicle operators to drive via **INTRASTATE** only with a history of epilepsy or any other condition likely to cause loss of consciousness or any loss of ability to control a motor vehicle to apply for a waiver from Federal Regulation 49 CFR 391.41(b)(8). **The process to determine if such a waiver may be granted includes a thorough review of documents provided and information that would support the request for a waiver.**

**ALL APPLICANTS MUST REVIEW THE FOLLOWING CRITERIA BEFORE APPLYING FOR AN INTRASTATE SEIZURE WAIVER:**

**EPILEPSY/SEIZURE DISORDER DIAGNOSIS:** The applicant must be seizure-free for eight (8) years on or off medication. If anti-seizure medication has been stopped, the driver applicant must be seizure-free for eight (8) years from the date the medication was discontinued. If the applicant is taking anti-seizure medication(s), the plan for medication(s) must be stable for two (2) years. **Stable means no changes in medication, dosage or frequency of administration.**

**SINGLE UNPROVOKED SEIZURE:** If there is a single unprovoked seizure (i.e. no known trigger for the seizure), the driver applicant should be seizure-free for four (4) years, on or off medication. If taking anti-seizure medication(s), the plan for medication should be stable for two (2) years.

**SINGLE PROVOKED SEIZURE:** If there is a single provoked seizure (i.e. there is a known reason for the seizure), the DMV considers specific criteria that fall into the following two categories:

**1. LOW RISK FACTORS:** This includes seizures caused by medication; by non-penetrating head injury with loss of consciousness less than or equal to thirty (30) minutes; by brief loss of consciousness not likely to recur while driving; by metabolic imbalance not likely to recur; and by alcohol or illicit drug withdrawal. Time required to be seizure-free for a patient with a low risk factor will be reviewed on a case by case basis and may be subject to referral to the Medical Advisory Board (MAB).

**2. MODERATE-TO-HIGH RISK FACTORS:** This includes seizures caused by non-penetrating head injury with loss of consciousness or amnesia greater than thirty (30) minutes; penetrating head injury; intracerebral hemorrhage associated with a stroke or trauma; infections; intracranial hemorrhage; post-operative complications from brain surgery with significant brain hemorrhage; brain tumor; or stroke. Patients who are moderate-to-high risk factors for recurrence should be seizure-free for eight (8) years on or off medication.

**APPLICANT'S ACKNOWLEDGEMENT:**

I have read and fully understand the information provided on pages 1 and 2 regarding the required criteria which must be met in order to be eligible to begin the application process for an Intrastate Seizure Waiver.

Applicant's Name (Please Print)

Applicant's Signature

CT License Number

**APPLICANT'S CERTIFICATION:**

Pursuant to 49 CFR 391.41 (b)(1-13) and 49 CFR 391.44, Section 14-44e of the Connecticut General Statutes, as amended, and all applicable laws, including the Regulations of Connecticut State Agencies, I hereby certify that I believe I am otherwise qualified to safely operate a commercial motor vehicle.

In accordance with the provisions of Sections 14-110 and 53a-157b of the Connecticut General Statutes, I swear or affirm under penalty of false statement, that the information contained herein, is true and accurate. I understand that if I make a statement that I do not believe to be true, with the intent to mislead the Commissioner of Motor Vehicles, I may be subject to criminal prosecution under the above-cited laws.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

**APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize the medical examiner completing and signing this medical report to release this report to the DMV, along with any other medical information necessary to determine my fitness to operate a commercial vehicle safely.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

**PART 2 - TO BE COMPLETED BY THE MEDICAL EXAMINER, BASED ON THE RESULTS OF A PERSONAL EXAMINATION CONDUCTED WITHIN NINETY (90) DAYS OF THE COMPETITION OF THIS REPORT. ATTACH OTHER INFORMATION AS NECESSARY, INCLUDING ANY TECHNICAL REPORTS OF TEST RESULTS.**

- DATE OF EXAMINATION: \_\_\_\_\_
- INDICATE THE DIAGNOSIS AND INCLUDE THE DATE OF ONSET: \_\_\_\_\_  
\_\_\_\_\_

- DATE(S) OF LAST EPISODE(S) OF ALTERED CONSCIOUSNESS OR AWARENESS - MONTH/YEAR AND CAUSE:  
Section 14-45a-5(a) defines altered consciousness as a state of awareness characterized by loss, distortion, or unresponsiveness to the impressions made by the senses.  
\_\_\_\_\_  
\_\_\_\_\_

- HAS THE APPLICANT BEEN DIAGNOSED WITH A **SINGLE PROVOKED SEIZURE?**  YES\*  NO  
\* If **YES**, is the factor for recurrence **LOW RISK OR MODERATE-TO-HIGH?**  
 **LOW RISK**  **MODERATE-TO-HIGH RISK**

- HAS THE APPLICANT BEEN DIAGNOSED WITH A **SINGLE UNPROVOKED SEIZURE?**  YES\*  NO  
\* If **YES**, have they been seizure-free for four (4) years on or off medication?  YES  NO

- HAS THE APPLICANT BEEN DIAGNOSED WITH A **SEIZURE DISORDER/EPILEPSY?**  YES\*  NO  
\* If **YES**, have they been seizure-free for eight (8) years on or off medication?  YES  NO

- IF THIS APPLICANT IS TAKING ANTI-SEIZURE MEDICATION(S) INDICATE DOSAGE AND FREQUENCY.

**CHECK HERE IF NOT ON ANTI-SEIZURE MEDICATION(S).**

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>

**PART 2 (CONTINUED FROM PAGE TWO) - TO BE COMPLETED BY THE MEDICAL EXAMINER, BASED ON THE RESULTS OF A PERSONAL EXAMINATION CONDUCTED WITHIN NINETY (90) DAYS OF THE COMPLETION OF THIS REPORT. ATTACH OTHER INFORMATION AS NECESSARY, INCLUDING ANY TECHNICAL REPORTS OF TEST RESULTS.**

8. THE PLAN FOR MEDICATION IS STABLE; NO CHANGES IN MEDICATION, DOSAGE, OR FREQUENCY OF ADMINISTRATION.

YES       NO

9. DATE OF LAST CHANGE IN ANY MEDICATION, DOSAGE, OR FREQUENCY,

Month/Year \_\_\_\_\_ Type of Change \_\_\_\_\_

CHECK HERE IF NO CHANGE

10. IF ANTI-SEIZURE MEDICATION(S) WAS DISCONTINUED, INDICATE DATE, AND HOW LONG THE APPLICANT HAS BEEN STABLE SINCE THE MEDICATION HAS BEEN DISCONTINUED.

CHECK HERE IF MEDICATION HAS NOT BEEN DISCONTINUED.

Name of Medication	Date Discontinued	Stable Since (month/year)

11. PLEASE INDICATE ANY ADDITIONAL FINDINGS UPON EXAMINATION AND INCLUDE ANY LABORATORY AND/OR DIAGNOSTIC TESTS THAT WERE PERFORMED AND THE SUBSEQUENT FINDINGS. ALSO INCLUDE A LIST OF ALL MEDICATIONS, THAT THE APPLICANT IS TAKING.

Findings: \_\_\_\_\_

Laboratory tests and results: \_\_\_\_\_

Diagnostic tests and results: \_\_\_\_\_

Medications: \_\_\_\_\_

12. IN YOUR MEDICAL OPINION, DO YOU BELIEVE THAT THIS APPLICANT MAY SAFELY OPERATE A COMMERCIAL MOTOR VEHICLE?

YES       NO

PHYSICIAN MUST PROVIDE INITIALS AND DATE: \_\_\_\_\_

13. DOES THIS CONDITION WARRANT PERIODIC MEDICAL REPORTING?       YES\*       NO

\* IF YES, PLEASE INDICATE SUGGESTED MONITORING INTERVALS:

Every \_\_\_\_\_ (months) for \_\_\_\_\_ (years).

**MEDICAL EXAMINER'S CERTIFICATION:**

I hereby certify that I have personally examined this applicant within ninety (90) days of completion of this report. In accordance with the provisions of Sections 14-110 and 53a157b of the Connecticut General Statutes, I swear or affirm, under penalty of false statement, that the information contained herein, is true and accurate. I understand that if I make a statement that I do not believe to be true, with the intent to mislead the Commissioner of Motor Vehicles, I may be subject to criminal prosecution under the above-cited law.

PHYSICIAN'S NAME (Please Print or Type)	SPECIALTY	EXAMINATION DATE
PHYSICIAN'S ADDRESS		TELEPHONE NUMBER
PHYSICIAN'S SIGNATURE <b>X</b>	LICENSE NUMBER	DATE SIGNED