



Driver Fitness
Programme de vérification de l'aptitude à conduire
C.P. Box 6300
Winnipeg MB R3C 4A4
Tel./ Tél: 204-985-1900
Fax/Télé: 204-953-4992 Email: Driverfitness@mpi.mb.ca

REPORT TO THE REGISTRAR OF MOTOR VEHICLES CONCERNING THE DISEASE OR DISABILITY OF PERSON PURSUANT TO SECTION 18.2(1) OF THE DRIVERS AND VEHICLES ACT

Patient Information (name and date of birth are required)

Name:	Address:	Date of Birth:
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Patient Medical Information (required)

Provide a brief description of disease or disability and the manner in which it may interfere with safely driving a motor vehicle. Include date of occurrence, if applicable. If vision related, include uncorrected and corrected visual acuity, pathology, and horizontal fields.

Recommendations

- Withdrawal of driving privileges pending further investigation
- Other recommendations (provide details below)

Additional Information

Physician's or Optometrist's Name

Signature of Reporting Physician or Optometrist

Date

Telephone Number/Address

Once complete and signed, send this form to Driver Fitness.
For information on Medical Standards for Drivers, please visit the [Information for health care professionals](#) page at mpi.mb.ca.