Brotherhood Mutual
Insurance Company

# Physician's Certificate for Vehicle Operator

*(This must be filled out by a physician)*

Named insured: ______________________ Policy number: ______________

Name of vehicle operator: ______________________ Age: ______________

Address of vehicle operator: ______________________________________

Has the vehicle operator had any loss or reduction of vision? ❑ Yes ❑ No

Is the vehicle operator color blind? ❑ Yes ❑ No

Has the vehicle operator had any loss or reduction of hearing? ❑ Yes ❑ No

To your knowledge, has the vehicle operator ever suffered from any of the following? If yes, when?

- Convulsions: ❑ Yes ❑ No ______________
- Attacks of unconsciousness: ❑ Yes ❑ No ______________
- Dizzy spells: ❑ Yes ❑ No ______________
- Diabetes: ❑ Yes ❑ No ______________
- Epilepsy: ❑ Yes ❑ No ______________
- Heart attacks: ❑ Yes ❑ No ______________
- Chronic illness: ❑ Yes ❑ No ______________
- Physical impairment: ❑ Yes ❑ No ______________

Does the vehicle operator have any stiffness or arthritis to the extent that it interferes with the use of upper and lower extremities? ❑ Yes ❑ No

Are the vehicle operator's reflexes normal? ❑ Yes ❑ No

Average blood pressure reading: ______________________

Is the vehicle operator currently or in the past enrolled in any Alcohol or Drug rehabilitation program: ❑ Yes ❑ No

Does driver's license have physical restrictions? If yes, please explain: ______________

______________________________________

**The following questions are to be completed by the physician after talking to the vehicle operator and observing the reactions.**

Do you think the vehicle operator is capable of safely operating an automobile? ❑ Yes ❑ No

What is your impression the vehicle operator's general physical and mental condition with respect to the ability to drive an automobile? ______________________

______________________________________

Additional comments: ______________________

______________________________________

Physician's signature: ______________________ Date: ______________

Signature of vehicle operator, authorizing the release of this medical report to Brotherhood Mutual:

Signature: ______________________ Date: ______________