



**METROPOLITAN TAXICAB COMMISSION
LICENSING DIVISION
MEDICAL EXAMINATION FOR MTC DRIVER'S PERMIT**

FORM
401.2(f)
(REV. 8-06)

PLEASE TYPE OR PRINT

NAME OF APPLICANT (LAST, FIRST, MIDDLE)		DATE OF BIRTH
STREET ADDRESS		SEX <input type="checkbox"/> M <input type="checkbox"/> F
CITY, STATE, ZIP CODE	DRIVER LICENSE NUMBER	STATE

VISION EXAMINATION

COLOR VISION DEFICIENCY <input type="checkbox"/> YES <input type="checkbox"/> NO	IF LENS/LENSES WORN DURING VISION TEST, RECORD IN CORRECTED BOX.											
	ACUITY	LEFT	RIGHT	BOTH	ACUITY	LEFT	RIGHT	BOTH	ACUITY	LEFT	RIGHT	BOTH
DO YOU WEAR CONTACT LENSE <input type="checkbox"/> YES <input type="checkbox"/> NO	NO AID	20/	20/	20/	COR-RECTED	20/	20/	20/	FIELD	°	°	°

IF THE VISION SPECIALIST COMPLETING THE EXAMINATION IS DIFFERENT THAN THE MEDICAL EXAMINER COMPLETING THE REMAINING PART OF THIS FORM, PLEASE SIGN.

PRINTED VISION SPECIALIST'S NAME ▶	VISION SPECIALIST'S SIGNATURE ▶	DATE OF EXAMINATION	MEDICAL LICENSE NUMBER
ADDRESS INCLUDING CITY, STATE, ZIP CODE			OFFICE TELEPHONE NUMBER ()

HEARING EXAMINATION


LEFT EAR	RIGHT EAR							
DISEASE OR INJURY		HEARING AID <input type="checkbox"/> YES <input type="checkbox"/> NO						
AUDIOMETRIC TEST (COMPLETE ONLY IF AUDIOMETER IS USED) DESCRIBE LOSS AT:								
500 HZ	LEFT	RIGHT	1,000 HZ	LEFT	RIGHT	2,000 HZ	LEFT	RIGHT

IF THE MEDICAL EXAMINER COMPLETING THE HEARING EXAMINATION IS DIFFERENT THAN THE MEDICAL EXAMINER COMPLETING THE REMAINING PART OF THIS FORM, PLEASE SIGN.

PRINTED MEDICAL EXAMINER'S NAME ▶	MEDICAL EXAMINER'S SIGNATURE ▶	DATE OF EXAMINATION	MEDICAL LICENSE NUMBER
ADDRESS INCLUDING CITY, STATE, ZIP CODE			OFFICE TELEPHONE NUMBER ()

HEALTH HISTORY

EXISTING CONDITIONS

<table style="width:100%;"> <tr> <td>YES</td> <td>NO</td> </tr> <tr> <td>HEAD OR SPINAL INJURIES</td> <td>●</td> <td>●</td> </tr> <tr> <td>SEIZURES, FITS, FAINTING, CONVULSIONS OR DIZZINESS</td> <td>●</td> <td>●</td> </tr> <tr> <td>CARDIOVASCULAR DISEASE</td> <td>●</td> <td>●</td> </tr> <tr> <td>NEUROLOGICAL OR MENTAL DISORDERS</td> <td>●</td> <td>●</td> </tr> <tr> <td>OTHER</td> <td>●</td> <td>●</td> </tr> </table>	YES	NO	HEAD OR SPINAL INJURIES	●	●	SEIZURES, FITS, FAINTING, CONVULSIONS OR DIZZINESS	●	●	CARDIOVASCULAR DISEASE	●	●	NEUROLOGICAL OR MENTAL DISORDERS	●	●	OTHER	●	●		<table style="width:100%;"> <tr> <td>YES</td> <td>NO</td> </tr> <tr> <td>ACTIVE TUBERCULOSIS TEST</td> <td>●</td> <td>●</td> </tr> <tr> <td>CURRENT COMMUNICABLE DISEASE</td> <td>●</td> <td>●</td> </tr> <tr> <td>LESS THAN NORMAL USE OF ARMS, HANDS, LEGS AND FEET</td> <td>●</td> <td>●</td> </tr> <tr> <td>EVIDENCE - ALCOHOL/DRUG USE</td> <td>●</td> <td>●</td> </tr> <tr> <td>IS APPLICANT ON SEDATIVE DRUGS/BLOOD PRESSURE MEDICATION?</td> <td>●</td> <td>●</td> </tr> <tr> <td>OTHER</td> <td>●</td> <td>●</td> </tr> </table>	YES	NO	ACTIVE TUBERCULOSIS TEST	●	●	CURRENT COMMUNICABLE DISEASE	●	●	LESS THAN NORMAL USE OF ARMS, HANDS, LEGS AND FEET	●	●	EVIDENCE - ALCOHOL/DRUG USE	●	●	IS APPLICANT ON SEDATIVE DRUGS/BLOOD PRESSURE MEDICATION?	●	●	OTHER	●	●
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EXPLAIN ANY CONDITIONS INDICATED ABOVE		EXPLAIN ANY CONDITIONS INDICATED ABOVE.																																					

ANY NOTABLE PROBLEMS WITH BLOOD PRESSURE? ● YES ● NO

BLOOD PRESSURE	URINALYSIS
SYSTOLIC: DIASTOLIC:	SUGAR: ALBUMIN:
LUNGS	HEART
NOSE AND THROAT	

COMMENTS ON ABNORMAL FINDINGS: _____

I CERTIFY I HAVE EXAMINED THE INDIVIDUAL NAMED ABOVE AND FIND THAT THIS PERSON IS IS NOT PHYSICALLY QUALIFIED TO SAFELY OPERATE A VEHICLE TRANSPORTING THE PUBLIC.

PRINTED MEDICAL EXAMINER'S NAME ▶	MEDICAL EXAMINER'S SIGNATURE ▶	DATE OF EXAMINATION	MEDICAL LICENSE NUMBER
ADDRESS INCLUDING CITY, STATE, ZIP CODE			OFFICE TELEPHONE NUMBER ()

IMPORTANT: PLEASE READ BEFORE COMPLETING THE MEDICAL FORM

PHYSICAL QUALIFICATIONS FOR DRIVERS TRANSPORTING THE PUBLIC

A DRIVER SHALL:

1. Be in good physical and mental health,
2. Be free from communicable diseases,
3. Have normal use of both arms, hands, legs and feet,
4. Have at least 20/40 vision in either eye, with correction if necessary,
5. Be able to distinguish the colors of red, green and yellow,
6. First perceive a forced whispered voice in the better ear at not less than five (5) feet with or without the use of a hearing aid, or if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz and 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard Z24.5-1951, and
7. Refrain from driving under the influence of intoxicants, narcotics, or drugs.

INSTRUCTIONS FOR PERFORMING MEDICAL EXAMINATION

The medical examiner should review these instructions before performing the medical examination. Answer each question. The medical examiner must be licensed in medicine or osteopathy and is required to certify that the applicant does not have any physical, mental, or organic defect of such a nature as to affect his or her ability to safely operate a vehicle transporting the public.

Eyes - Test applicant's visual acuity with and without corrective lenses, as applicable. In recording distance vision use 20 feet as normal. Report all vision as a fraction with 20 as the numerator and the smallest type read at 20 feet as the denominator. Note color blindness or other defects which would impair ability to safely operate a vehicle transporting the public.

Ears - When recording hearing, record distance at which whispered voice can first be heard. If audiometer is used to test hearing, record decibel loss at 500 Hz, 1,000 Hz, 2,000 Hz. Note whether hearing aid is utilized during testing and any disease or injury which would affect ability to safely operate a vehicle transporting the public.

Health History - History of certain defects may be cause for rejection or may indicate further examination is required. Any health history item to which the response is positive, should be discussed with the applicant and described in the "Comment" portion of the examination.

Existing Conditions - Certain existing conditions would be cause for rejection. Review the criteria outlined above to determine which existing conditions would result in rejection. Note any physical signs of drug or alcohol use or use of any medication which would impair ability to safely operate a vehicle transporting the public.

Blood Pressure - Record blood pressure, if blood pressure is abnormal, make comments as appropriate.

Urinalysis - Urinalysis is required to test for sugar and albumin. Note any abnormalities requiring additional testing or which would affect safe operation of a vehicle transporting the public.

Lungs - Note confirmed shortness of breath, audible wheezing, or other condition(s) that would affect safe operation of a vehicle transporting the public.

Heart - Stethoscopic examination is required. Note murmurs and arrhythmias, signs of cardiovascular disease or other defects that would affect safe operation of a vehicle transporting the public.

Nose and Throat - Note any evidence of disease or deformity likely to interfere with breathing or any other condition that would interfere with the safe operation of a vehicle transporting the public.

The medical examiner must sign, date, provide address, telephone number and medical license number as indicated on the medical examination form.

Please send this completed medical examination to:

Metropolitan Taxicab Commission
100 North Tucker Blvd., Suite 110
St. Louis, MO 63101

Telephone: (314) 241-7600
Fax: (314) 241-7603
Web: www.stl-taxi.com

VISIT OUR WEBSITE AT WWW.STL-TAXI.COM