

**CLINIQUE MEDICALE PHYSERGO
APPLICATION FOR EVALUATION
OF THE APTITUDE FOR DRIVING A VEHICLE**

Last name: _____ **Date of application:** _____
First name: _____ **Date of birth:** _____
Address: _____ **Social insurance number:** _____

_____ **Telephone - Home:** _____
- **Work:** _____
- **Other:** _____

Driver / New
 Experienced

Driver's permit No.: _____ Expiration date: _____

MAIN DIAGNOSIS: related conditions, major problems, medication, etc.

** If possible, forward a summary of the medical records and, in cases of head injury, submit a neuro-psychological evaluation.

Referred by: _____ Institution/organization: _____

Signature: _____ Address: _____

Occupation: _____

Telephone: _____ Postal code: _____

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I, _____, hereby authorize, _____
to disclose all the information necessary for my rehabilitation to Clinique médicale Physergo du Sud-Ouest.

SIGNATURE: _____ DATE: _____

Must be signed by the person referred or the legal guardian

WITNESS:

Send by fax to: 514.766.3472