

29 DEPARTMENT OF SECRETARY OF STATE

250 BUREAU OF MOTOR VEHICLES

Chapter 3: PHYSICAL, EMOTIONAL AND MENTAL COMPETENCE TO OPERATE A MOTOR VEHICLE

SUMMARY: These rules describe the standards to be used by the Secretary of State in determining physical, emotional and mental competence of persons to operate motor vehicles. The rules establish a reporting system which requires persons to submit medical information to the Secretary of State. Persons found incompetent to operate a motor vehicle in accordance with procedures outlined in these rules may have their driving privileges suspended, revoked or restricted.

1. Standards

- A. Secretary of State. The Secretary of State shall determine the physical, emotional, and mental competence of a person to operate a motor vehicle with the advice of the Medical Advisory Board and on the basis of the Functional Ability Profiles.
- B. Functional Ability Profiles. Standards to determine the competence of a person to operate a motor vehicle are those contained in the "Functional Ability Profiles" adopted by the Secretary of State with the assistance of the Medical Advisory Board.

2. Reporting System

- A. Medical conditions requiring report. Conditions for which a person is required to submit a report to the Secretary of State include, but are not limited to, neurological, cardiovascular, metabolic, musculoskeletal, visual, emotional and psychiatric and substance abuse.
- B. Sources of information. Sources of information concerning medical conditions include, but are not limited to:
 - 1. Permits, licenses, renewal applications, and accident reports;
 - 2. Written reports from family, physicians, law enforcement personnel and other government agencies, and;
 - 3. Signed statements from citizens.

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- C. Nature of medical report. Upon receipt of information concerning the existence of a medical condition for which a report is required or which may affect a person's ability to operate a motor vehicle, the Secretary of State shall request the person involved to submit a medical report from a physician or from other competent treatment personnel, who may be specified.
1. To be acceptable, the medical report must be made on forms supplied or approved by the Secretary of State and must contain the physician's or other treatment personnel's diagnosis of the patient's condition(s) and any prescribed medication(s).
 2. The Secretary of State may require an individual to certify in writing the date of the person's last seizure.
- D. Action by the Secretary of State
1. Upon receipt of a medical report indicating that a person is competent to operate a motor vehicle, the Secretary of State may approve the person's competence to operate a motor vehicle, with or without restrictions, taking into consideration the safety of the public and the welfare of the driver.
 2. Upon receipt of a medical report indicating that a person is not competent to operate a motor vehicle, or upon the failure or refusal of a person to submit the requested information, the Secretary of State shall follow one or more of the following procedures:
 - a. If, from records or other sufficient evidence, the Secretary of State has cause to believe that a person is not physically, emotionally, or mentally competent to operate a motor vehicle, the Secretary of State may:
 - i. Obtain the advice of any member of the Medical Advisory Board or the Board collectively. The Board or any member may formulate advice from the existing records and reports or may request that an examination and report be made by the Board or any other qualified person so designated. The licensed driver or applicant may present a written report from a physician of the person's choice to the Board or the member reviewing the matter and such report must be given due consideration. Members of the Board and other persons making examinations and reports are not liable for their opinions and recommendations pursuant to this subsection.

- ii. Require a person to submit to a driving evaluation. Upon the conclusion of such an evaluation, the Secretary of State shall take action as may be appropriate. The Secretary of State may suspend the license of such person, allow the person to retain a license, or issue a license subject to any conditions or restrictions deemed advisable, having in mind the safety of the public and the person.
 - iii. After hearing, suspend any certificate of registration, operator's license, operating privileges, or privilege to apply for and obtain a license in the State of Maine.
 - iv. Without preliminary hearing, suspend any certificate of registration or any operator's license, operating privilege, or privilege to apply for and obtain a license in the State of Maine if the Secretary of State determines that the person's continued operation of a motor vehicle presents a potential danger to the person or other persons or property. The Secretary of State shall notify the person that a hearing will be provided without undue delay.
- E. Confidentiality of reports. Reports received under this rule are confidential in accordance with the Maine Motor Vehicle Statutes.

FUNCTIONAL ABILITY PROFILES

Functional ability to operate a vehicle safely may be affected by a wide range of physical, mental or emotional impairments. To simplify reporting and to make possible a comparison of relative risks and limitations, the Medical Advisory Board has developed Functional Ability Profiles for ten categories, with multiple levels under each profile. Each profile follows the same format:

1. **No diagnosed condition.** This section is used for a patient who has indicated to the Bureau of Motor Vehicles a problem for which no evidence is found, or for which no ongoing condition can be identified. For example, this category might apply to a person with a heart murmur as a young child who indicates heart trouble, or to a teenager who fainted in gym class once on a hot day who indicates blackouts.
2. **Condition, fully recovered/compensated.** This category indicates a history of a condition which has been resolved or which does not warrant review. Guidance for the use of this section is given in each profile.

3. **Active impairment.**
 - a. **Minimal.** This section may call for periodic review because of an ongoing condition which could deteriorate.
 - b. **Mild.** This section deals with conditions which may impair driving but which are controlled so that a person can still operate a motor vehicle safely. Reviews are more frequent than in (a).
 - c. **Moderate.** This section identifies impairment which often precludes driving, but for which there is the potential for recovery to the point of allowing safe operation of a motor vehicle.
 - d. **Severe.** This section identifies permanent conditions with little or no potential for improvement and which preclude safe operation of a motor vehicle.
4. **Condition under investigation.** This section is for newly identified conditions. Follow-up reports will place condition in its proper part of section 3.

In all cases, periodic reviews may place the driver being evaluated in a higher or lower section as the condition improves or deteriorates.

CARDIOVASCULAR DISORDERS

Cardiovascular disease may affect a driver's ability in a variety of ways. For this reason, profile guidelines are shown for some of the more common circumstances.

Atherosclerotic Heart Disease/Congestive Heart Failure:

This profile is used for any patient having the clinical diagnosis Atherosclerotic Heart Disease or Congestive Heart Failure (any etiology). The levels are based on the functional classification of the American Heart Association.

Class 1. Patients with heart disease but with no limitations of physical activity. Ordinary physical activity causes no undue dyspnea, anginal pain, fatigue or palpitations.

Class II. Patients with slight limitations of physical activity. They are comfortable at rest and with mild exertion. They experience symptoms only with the more strenuous grades of ordinary activity.

Class III Patients with marked limitations of physical activity. They are comfortable at rest, but experience symptoms even with the milder forms of ordinary activity.

Class IV. Patients with inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present, even at rest, and are intensified by activity.

Supraventricular Arrhythmia and Cardiac Syncope:

In general, the first two levels of this profile apply to individuals whose arrhythmia has been of a minor nature or so remote and well controlled that the patient is expected to drive without presenting a risk to the public. In more severe cases, careful documentation of both subjective and objective findings is required because of the intermittent, unpredictable, and potentially very severe degrees of impairment associated with arrhythmias.

Ventricular Tachycardia and Ventricular Fibrillation:

Implantable anti-tachycardia devices (AICD's PCD's, etc.) and patients who have them present special circumstances and problems. Generally, a patient who receives such a device for a presenting rhythm which led to loss of consciousness (e.g., sudden death or syncope) should not drive for six months. If experience shows that a recurrence of such an event will be effectively treated by the device without loss of consciousness, driving may be resumed. If six months elapses without an event, then driving may be resumed. Patients who have devices implanted for non-syncopal rhythms may be allowed to resume driving immediately postoperatively. It is important to note that each of these is a discrete decision and must be considered individually.

Hypertension:

Apart from its complications, hypertension is largely an asymptomatic condition and in itself does not impair fitness to drive. Medications which may have a sedative side effect or cause unexpected orthostatic hypotension must be assessed by the physician as to their effect on driving. Visual, neurological or cardiovascular complications should be profiled under other categories.

FUNCTIONAL ABILITY PROFILES: Cardiovascular Disorders
Ventricular Tachycardia/Ventricular Fibrillation¹

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Arrhythmia by history, not documented, asymptomatic	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Nonsyncopal nonsustained ventricular tachycardia b. 1. Sustained VT without syncope under treatment 2. VT or VF treated with medication or ICD greater than 6 months without syncope or LOC. If ICD-no pre or post shock syncope, alteration of consciousness, or interference with ability to control a motor vehicle. c. Same as b. 2) above under treatment less than 6 months or syncope pre or post ICD discharge d. Documented syncopal arrhythmia not responding to treatment	a. 4 years b. 2 years c. No driving d. No driving
4.	Condition under investigation	Newly identified ventricular tachycardia or recent ventricular fibrillation	As needed
Including implantable cardioverter defibrillators (ICDs)			

¹ * For further explanation refer to page 1

FUNCTIONAL ABILITY PROFILE: Cardiovascular Disorders
Supraventricular Arrhythmias¹/Cardiac Syncope/Bradyarrhythmias

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	a. Arrhythmias by history, not documented, asymptomatic; b. Documented arrhythmias (excluding ventricular tachycardia or fibrillation) with none in the last 18 months and no other identified heart disease.	Driver responsible to report any changes
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Documented arrhythmias >18 months (excluding ventricular tachycardia or fibrillation) asymptomatic b. Documented arrhythmias within 6-18 months (excluding ventricular tachycardia or fibrillation) on or off medication, symptomatic with or without syncope within 6-18 months c. Documented arrhythmias <6 months associated with syncope or syncope of any cause (excluding ventricular tachycardia or fibrillation); unstable. d. Documented primary ventricular tachycardia or fibrillation. Cardiac syncope due to uncontrollable arrhythmias.	a. 4 years b. 2 years c. No driving d. No driving
4.	Condition under investigation	Newly identified arrhythmias.	As needed
¹ Excludes transient arrhythmias or conduction defects associated with acute myocardial infarction. ² Definitive therapy for prevention of syncope may allow driving in <6 months on an individual basis.			

* For further explanation refer to page 1

FUNCTIONAL ABILITY PROFILE: Cardiovascular Disorders: Atherosclerotic Heart Disease (ASHD), Congestive Heart Failure (CHF), Status Post Myocardial Infarction (MI)

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Currently asymptomatic and: a. History of chest pain without documented CAD or b. AHA Class I or c. S/P MI 1 year.	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. AHA Class II; CHF, compensated. b. AHA Class III; S/P MI within 4 weeks-1 year c. S/P MI <4 WEEKS ¹ d. AHA Class IV, CHF or active unstable angina.	a. 2 years b. 1 year c. No driving d. No driving
4.	Condition under investigation	New onset of symptoms of heart disease.	As needed
¹ May be revised after review of individual circumstances.			

* For further explanation refer to page 1

DIABETES AND OTHER ENDOCRINOPATHIES.

Abnormalities of the endocrine system can cause altered consciousness, weakness, fatigue, lethargy, motor abnormalities, visual disturbances, tremors or psychiatric disorders. Such disorders include but are not limited to, diabetes, thyroid disorders, parathyroid disease, pituitary disorders and neuropathic disorders.

Once one of these conditions is diagnosed, evaluation should be undertaken by a physician to assess any degree of impairment. Any evaluation of one's driving should be assessed under the appropriate guidelines, e.g. diabetic retinopathy should be referred to the visual acuity profile. These disease processes should be under control to assure safe operation of a motor vehicle.

**FUNCTIONAL ABILITY PROFILE:
Diabetes and Other Endocrinopathies**

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Prior endocrinopathy, i.e. gestational diabetes.	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Active endocrinopathy, controlled without medication, i.e., diabetes, diet controlled. b. Active endocrinopathy, with medication, i.e. diabetes controlled with insulin or oral agents. c. Active endocrinopathy currently impairing driving functions but with potential for control. d. Uncontrollable endocrinopathy of sufficient severity to impair safe operation of a motor vehicle	a. N/A b. 8 years c. No driving d. No driving
4.	Condition under investigation	Newly discovered endocrinopathy	As needed

* For further explanation refer to page 1

HEAD INJURY

The neurological residuals from head injury are the result of direct brain contusions/infarctions and the "shear effect" where axonal connections are disrupted due to the force of impact. While the former lesions are discernable from CT scan and other diagnostic tests, the latter are more subtle but can be detected in alterations in behavior, personality and cognition.

The head injury patient differs significantly from one with a stroke syndrome. In addition to the obvious sensorimotor deficits and post-traumatic amnesia, after head injury, more subtle functional impairments in the area of behavior, altered personality, cognition, communication, judgment, spatial reasoning, problem solving, attention span, etc., are usually seen. These deficits, either singularly or in combination, may create a significant barrier to the safe operation of a motor vehicle. Judgment may be so affected that the victim does not even recognize the impairment.

A person with any head injury with residual impairments should not drive until the person's competence has been evaluated by a qualified driver license examiner experienced in the assessment of such cases. In the interval, it may be necessary for the Secretary of State to suspend the person's license since voluntary compliance may not be guaranteed.

Following head injuries, particularly where the surface of the brain has been penetrated, there is an increased incidence for seizures. Seizure disorders as an individual entity are covered elsewhere in this manual (page 16). Any driver with the diagnosis of head injury with secondary seizures must be reviewed separately under both sections since a road evaluation may be required under the former but not necessarily because of the latter.

**FUNCTIONAL ABILITY PROFILE:
HEAD INJURY**

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Any previous history of head injury with or without loss of consciousness with no residual cognitive deficits	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	Please indicate in comment area of form any cognitive or physical deficits a. Mild residual sensorimotor, visual or cognitive deficit from previous head injury not severe enough to impair safe driving ¹ b. Same as (a) , but ROAD EVALUATION REQUIRED¹ c. Significant deficits following recent head injury but with potential for improvement. d. Significant deficits following head injury with no potential for improvement.	a. N/A b. N/A c. No driving d. No driving
4.	Condition under investigation	Recent head injury	As needed
¹ Any questions should be resolved by a road evaluation with the Bureau of Motor Vehicles. ² Post traumatic seizures should be evaluated under the neurological profile.			

* For further explanation refer to page 1

HEARING LOSS/VERTIGO

In the State of Maine, hearing loss traditionally has not precluded driving. The deaf driver (hearing loss > 80dB) and even those with hearing impairments (correctable to no better than 60 dB) lack a warning system which other drivers on the road assume to be present. While it is possible to compensate for lack of hearing with other sensory input, especially visual, some deaf drivers do have an increased accident rate. Supplemental mirrors, warning lights, voluntary restriction to daylight driving, and special training may be required.

Drivers with permanent or unpredictable episodic vertigo not correctable with medications should be evaluated based on the following profile.

**FUNCTIONAL ABILITY PROFILE:
Vertigo**

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	History of vertigo, asymptomatic at least one year.	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Chronic mild vertigo b. Self limiting acute episodic vertigo stable with medication. c. All other vertigo not in (a) or (b), but with potential for recovery. d. Vertigo, the severity of which precludes the safe operation of a motor vehicle.	a. N/A b. N/A c. No driving d. No driving
4.	Condition under investigation	Newly discovered vertigo.	As needed

* For further explanation refer to page 1

NEUROLOGICAL AND RELATED MUSCULOSKELETAL CONDITIONS

Neurologic disorders have a significant impact on driving safety. A partial list would include: cerebrovascular disease, seizures, head injury, Parkinson's Disease, the various dementias and encephalopathies. Also included in a single miscellaneous category are the various musculoskeletal abnormalities which include muscular atrophies and dystrophies, myasthenia gravis, spinal cord disease, paraplegia, quadriplegia, and orthopedic deformities either congenital or acquired (such as arthritis or amputation). These musculoskeletal conditions have multiple etiologies, but the common need in most cases is adaptive driving equipment (hand controls, etc.) Multiple sclerosis, by virtue of its protean presentation, should be included under the profile which best describes its current functional impairment.

The common element in most of these is the disturbance of sensory, motor, cognitive, and/or coordinating functions sufficient to affect driving. Some of these, if stable, can be compatible with ability to operate a motor vehicle, if a driving test shows adequate performance in the type of vehicle to be driven. Other conditions, however, that have not yet stabilized or have a probability of progression or need for medication may require a medical report initially or at intervals.

Epilepsy includes any recurrent loss of consciousness or conscious control arising from intermittent change in the brain function. Other disorders, which also can affect consciousness or control, such as syncope, cataplexy, narcolepsy, hypoglycemia, episodic vertigo interfering with function or drop attacks, need also to be considered in a similar fashion.

In some neurologic disorders, there may be problems which fall into multiple categories. For example, a head injury may not only result in paralysis, but in visual field loss, impairment of learning and memory, and a seizure disorder. These should be addressed separately by the appropriate categories.

Because of society's increasing reliance on the automobile, limitations imposed upon the driving privilege of the elderly can significantly limit personal independence. While advancing age itself is not a predictor of individual driving ability, there are many conditions common in the elderly population which render the older operator more susceptible to vehicular accidents. Included among the age-related diagnoses are stroke, Parkinson's Disease, and dementia, particularly of the Alzheimer's variety. The diagnosis of an uncomplicated, stable dementia with memory impairment may not be sufficient cause to limit the driving privilege of an otherwise capable person. However, if complex reasoning skills are deficient, then such a driver presents a greater risk as evidenced by the fact that accidents in the older age group typically occur in complicated traffic patterns, intersections, lane changing, merging, left-hand turns, and emergencies. Unfortunately there is no adequate predriving test which can identify the competent driver with certainty. The road evaluation has been considered by some the "gold standard" to determine operating ability, but this only assesses routine functioning and cannot predict response to novel and emergency situations. Nevertheless, a road evaluation conducted by an experienced driver license examiner remains the best available measurement to assess operating skills including freedom from

distractibility. If family, friends or medical personnel question the fitness of an older driver, with or without the symptoms of dementia, then a road evaluation may be an appropriate measure either to limit the privilege for the incompetent individual or to recommend remedial training or adaptations for others so that their independence can be maintained within the bounds of public and personal safety.

FUNCTIONAL ABILITY PROFILE:
Miscellaneous Congenital or Acquired Anatomic/Musculoskeletal Chronic Conditions
Interfering with Normal Mechanical/Motor Functions of Joints and Limbs³

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Past history of disorder which currently does not impair driving and requires no compensating personal ¹ or non-standard accessory ² devices.	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Ongoing condition which currently does not impair driving and requires no compensating personal ¹ or non-standard accessory ² devices. b. Same as (a), but requires compensating personal ¹ or non-standard accessory ² devices. ROAD EVALUATION REQUIRED c. Ongoing condition which interferes with safe driving despite devices, but with potential for recovery. d. Same as (c), no potential for recovery.	a. 4 years b. 4 years c. No driving d. No driving
4.	Condition under investigation	Newly discovered abnormality or condition.	As needed
¹ . Prosthesis, brace, etc. ² . Hand controls ³ . Driving may need to be temporarily prohibited due to an immobilizing cast, neck brace, etc., if it impedes safe operation of a motor vehicle			

* For further explanation refer to page 1

FUNCTIONAL ABILITY PROFILE: Neurological Conditions
Dementia/Encephalopathies

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Dementias or encephalopathies recovered	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Diagnosed mild nonrapidly progressive Dementia/Encephalopathy. REQUIRES ROAD EVALUATION EVERY 2 YEARS b. Same as (a). More severe. Safe to drive limited distances. ROAD EVALUATION REQUIRED c. Dementia or encephalopathy interfering with driving at present or with poor compliance with potential for recovery. d. Non-treatable dementia	a. 2 years b. 1 year c. No driving d. No driving
4.	Condition under investigation	Newly diagnosed disturbance of higher integrative functions	As needed

* For further explanation refer to page 1

FUNCTIONAL ABILITY PROFILE: Neurological Conditions
Parkinson's Disease/Syndrome

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Past impairment fully recovered & compensated	History of drug induced Parkinsosnian Syndrome, now recovered	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Mild unilateral Parkinson's Disease controlled with medication. ROAD EVALUATION REQUIRED b. Bilateral Parkinson's Disease/Syndrome, moderate severity with signs of progression but still functionally capable of driving with medication. ROAD EVALUATION REQUIRED c. Bilateral Parkinson's Disease/Syndrome, the symptoms of which preclude driving at present but may improve with medication adjustment d. Advanced Parkinson's Disease, the severity of which precludes driving.	a. 4 years b. 1 year c. No driving d. No driving
4.	Condition under investigation	Recently discovered Parkinson's Disease/Syndrome	

* For further explanation refer to page 1

FUNCTIONAL ABILITY PROFILE: Neurological Conditions
Seizures¹ and Unexplained Episodic Alterations of Consciousness²

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Previous history of any seizure, but seizure free and off medication at least 2 years.	
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Seizure free at least 2 years, and off medication > 3 months ³ , Long standing (> 5 years) seizure disorder, on medications, seizure free at least 3 months. b. All other seizure disorders not covered in (a), on medications and seizure free for at least 3 months ⁴ c. Seizures not yet controlled or medications not adjusted d. 1. Uncontrollable seizure disorder. 2. Chronic noncompliance. 3. Medications which interfere with driving.	a. 4 years b. 2 years c. No driving d. No driving
4.	Condition under investigation	Newly discovered seizure disorder	As needed
<p>¹ Seizure disorder having more than one episode not explained by chemical/metabolic phenomenon. Seizures related to chemical abuse fall under this profile.</p> <p>² Any unexplained episodic alterations of consciousness including a single seizure episode, no driving is permitted for 6 months.</p> <p>³ If medication is being tapered, no driving is permitted until 3 months after medications have been discontinued.</p> <p>⁴ Breakthrough seizures in a known seizure disorder due to reduction in medication are not subject to the 3 month rule.</p>			

Interfering with Normal Mechanical/Motor Functions of Joints and Limbs³

* For further explanation refer to page

PSYCHIATRIC DISORDERS

There is no certain way of predicting which persons with psychiatric illness will have accidents, but many high risk drivers are such because of psychiatric conditions.

Many individuals with psychiatric illness are maintained on medications on an ambulatory status. These drugs have varying degrees of sedative side effects and can potentiate other central nervous system depressants. Persons receiving such medications should be screened in terms of severity of side effects incident to medication and the adequacy of the remission.

If a physician believes there may be a problem but is not sufficiently familiar with the patient's psychiatric status to make a valid judgment, he should refrain from doing so until he gains access to current psychiatric information or records or makes an appropriate referral for evaluation.

**FUNCTIONAL ABILITY PROFILE:
Psychiatric Disorders**

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Past history of psychiatric or behavioral disorder, asymptomatic, off medication	N/A
3.	Active impairment:		
	a. Minimal	a. Current psychiatric disorder without impaired judgment, destructive thinking or intent, controlled with or without medication.	a. 4 years
	b. Mild	b. Same as (a), with potential for impaired judgement. ROAD EVALUATION REQUIRED	b. 1 year
	c. Moderate	c. Active psychiatric/behavioral disorder with indications of risk to self or others; or with treatment or medications which interfere with alertness or coordination, but with potential for improvement	c. No driving
	d. Severe	d. Same as (c), not expected to recover.	d. No driving
4.	Condition under investigation	Newly discovered psychiatric/behavioral disorder	As needed

* For further explanation refer to page 1

PULMONARY DISORDERS

Most patients with chronic pulmonary diseases of various etiologies will have no difficulty maintaining their driving privilege. Two pulmonary disorders which deserve special attention are Chronic Obstructive Pulmonary Disease (COPD) and Sleep Apnea.

Those individuals suffering from COPD with dyspnea on exertion or at rest should be evaluated. As a guideline, the oxygen saturation should be measured to determine their oxygen-carrying capacity. Those using supplemental oxygen would also fall into this category.

Sleep apnea, left untreated, results in increased daytime sleepiness and decreased attentiveness. Several studies demonstrate that these patients have two to three times more auto accidents than other drivers. Almost one quarter of these patients report frequently falling asleep while driving. These patients showing significant improvement with successful treatment of their apnea, whether with nasal CPAP, surgical intervention (e.g., uvulopalatopharyngoplasty), weight loss or other treatment modalities, may safely drive.

Evaluation of the driver should take place after optimal medical treatment.

**FUNCTIONAL ABILITY PROFILE:
Chronic Obstructive Pulmonary Disease (COPD)**

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Restrictive, toxic, infectious broncho-spastic or obstructive lung disease, recovered	
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Pulmonary disease with episodic symptoms, controlled with medication. b. Mild-moderate dyspnea on exertion, no dyspnea at rest, O ₂ saturation > 88% with exertion ¹ c. Moderate-severe dyspnea on exertion, no dyspnea at rest, O ₂ saturation > 88% using supplemental oxygen. d. Same as (c). Cannot maintain O ₂ saturation > 88% with or without oxygen.	a. N/A b. 2 years c. 1 year d. No driving
4.	Condition under investigation	Newly discovered pulmonary disorder	As needed
¹ Current Medicare guidelines			

*For further explanation refer to page 1

**FUNCTIONAL ABILITY PROFILE:
Sleep Apnea Syndrome**

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Recovered after effective surgery or other measures, such as weight loss. Repeat polysomnogram no longer shows significant apneas.	N/A
3.	Active impairment:		
	a. Minimal	a. MSLT ¹ of 10-15 min., and/or Polysomnogram reveals presence of <10 apneas (no therapy).	a. 1 year
	b. Mild	b. MSLT ¹ of 5-10 min., and/or Polysomnogram reveals presence of 10 or more apneas/hour each lasting 10 or more seconds (no effective therapy) ² .	b. 1 year
	c. Moderate	c. MSLT of less than 5 min., and/or Polysomnogram reveals presence of 10 or more apneas/hour each lasting 10 or more seconds (on effective therapy) ² .	c. 1 year
	d. Severe	d. Unresponsive to therapy or non-compliance with therapy	d. No driving
4.	Condition under investigation	History of falling asleep while driving or strong suspicion for apnea.	No driving
¹ Multiple Sleep Latency Test ² Effective therapy defined as therapy resulting in repeat Polysomnogram that is normal			

* For further explanation refer to page 1

STROKE

The residual impairments from cerebral vascular accidents are multiple and range from sensorimotor deficits, communication impairments, to cognitive dysfunction. While some of these residua are evident and obviously preclude the operation of a motor vehicle, other deficits are more subtle but still constitute a contraindication to driving.

The more subtle deficits include those which influence visual/spatial reasoning motor planning, problem solving, judgment and visual field loss (refer to visual field profile). Such deficits as these present significant barriers to the safe operation of a motor vehicle since the stroke victim may have problems turning corners, staying on the road, responding to simultaneous challenges from both visual fields, and judging distances, to name a few. Many of these impairments may be brought out in a functional road test conducted by a qualified examiner.

The more obvious sensory motor losses with impairment of limb function present another type of disability. If this type of patient does not have the previously mentioned spatial disorientation, visual deficits and motor planning impairment, the person may be a candidate for driving a motor vehicle using adaptive equipment.

The stroke patient is the worst judge of the patient's capacity to drive since the brain damage may interfere with accurate self-assessment. The patient may appear "deceptively competent". The physician must, therefore, depend on the assessment of others experienced in the intricacies of driving evaluation. As a rule of thumb, a stroke patient should not drive unless the patient's ability has been demonstrated to an experienced driver license examiner.

FUNCTIONAL ABILITY PROFILE:
Stroke

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Past history of stroke with no residual sensorimotor, cognitive judgment, communicative or visual impairment, no seizures. No need for braces, canes or assistive devices.	N/A
3.	Active impairment:	Please indicate in comment area of form any cognitive or physical deficits	
	a. Minimal	a. History of stroke which no longer results in functional impairment of driving. Compensating personal ¹ or non-standard accessory devices ² may be used. REQUIRES ROAD EVALUATION	a. N/A
	b. Mild	b. Impaired use of upper extremity, ambulation with brace, assistive device (cane) sensorimotor deficit, cognitive or judgment impairment. REQUIRES ROAD EVALUATION	b. 4 years
	c. Moderate	c. Acute CVA with sufficient functional impairment to hinder current operation of a motor vehicle; has potential for improvement.	c. No driving
	d. Severe	d. Bilateral CVA's visual, cognitive and sensorimotor impairment, impulsiveness, poor judgment. Not expected to improve.	d. No driving
4.	Condition under investigation	Recent stroke	As needed
	NOTE: T.I.A. and amaurosis fugax, by virtue of their implications, require cessation of driving for at least one month and inclusion in condition under investigation.		
	¹ Prosthesis, brace, etc. ² Hand controls		

* For further explanation refer to page 1

SUBSTANCE ABUSE

The misuse of drugs and the abuse of alcohol statistically account for the majority of highway accidents, with alcohol alone being responsible for more than 50 per cent. The federal government has mandated that the states take action to curb this mayhem on our highways, and already the Maine State Legislature has enacted changes aimed at making our highways safer.

Driving is a privilege dependent upon one's having qualified to drive by meeting specific requirements for licensure. Although the driver has the primary responsibility for knowing when he or she is or is not physically or mentally capable of operating a vehicle in a safe manner, persons using drugs or alcohol are notably unreliable for such self-assessment, and the physician, therefore, has an obligation to participate in this evaluation:

By educating persons regarding effects of acute and chronic use of alcohol, drugs, or combination of these and with particular reference to driving ability.

By recognizing high risk individuals through an awareness of the history and/or symptoms of acute and chronic substance abuse, such as gastrointestinal symptoms, often atypical; injuries or burns of vague causation; neurological symptoms; general medical or flu-like symptoms; social maladjustment and interpersonal and work difficulties; and family health problems.

By recommending to those persons on medications whether the medications may impair one's ability to drive safely.

The following profile should aid physicians in suspected cases of substance abuse.

FUNCTIONAL ABILITY PROFILE:
Substance Abuse¹

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	No known disorder.	
2.	Condition fully recovered & compensated	Past history of substance use/abuse, substance free without history of personal or social consequences for the past 6 years.	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Occasional substance use without history of personal or social consequences for the past 6 years. b. Chronic substance use without impairment of motor and/or intellectual functions and without history of personal or social consequences for the past 6 years. ROAD EVALUATION REQUIRED c. Chronic substance use/abuse resulting in current impairment of motor and/or intellectual functions d. Chronic substance use/abuse resulting in permanent mental or physical impairment affecting operation of a motor vehicle	a. 4 years b. 1 year c. No driving d. No driving
4.	Condition under investigation	Newly discovered substance use/abuse including withdrawal syndromes	As needed
¹ Including medication, alcohol and illicit drugs.			

* For further explanation refer to page 1

VISUAL DISORDERS

The main elements of vision necessary for safe driving are visual acuity, peripheral vision and freedom from double vision (diplopia) These three items are elaborated in the following charts on visual parameters. Other, not so easily measured visual factors, are discussed below:

Defects in color vision, important in distinguishing traffic signals, are usually compensated for by learning traffic light positions and are not in themselves reasons to deny driving but will usually have been tested adequately by the road evaluation.

Night vision and glare recovery may be impaired in the presence of corneal scars, cataracts, and retinal disease.

Dynamic visual acuity (acuity measured when there is movement of a driver or object) and speed blur are important to keep in mind since speed and motion appear to decrease acuity and peripheral vision.

Physician judgment and counseling of the driver as well as recommendations to the driver examiner to look for problems caused by the above defects will be helpful in identifying drivers whose visual disorders may be a hazard even though it cannot be measured by standard visual tests.

FUNCTIONAL ABILITY PROFILE: Visual Disorders
Double Vision

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No diagnosed condition	Never sees double	
2.	Condition fully recovered & compensated	Past history of diplopia which has recovered	Per Recommendation
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Eyes crossed but no diplopia without patch. b. Intermittent diplopia or constant double vision correctable by patching one eye. c. Monocular diplopia in only eye meeting visual acuity standards with potential for correction. d. Monocular diplopia in only eye meeting visual acuity standards without potential for correction	a. N/A b. 4 years c. No driving d. No driving
4.	Condition under investigation	Recent onset of diplopia.	As needed

* For further explanation refer to page 1

**FUNCTIONAL ABILITY PROFILE:
Peripheral Vision**

Profile Levels	Circumstances*	Condition Example	Interval for Review
1.	No known impairment.	Binocular visual field of at least 150° measured with a 10mm white test object at 330mm, without corrective lenses, in the horizontal meridian.	
2.	Condition fully recovered & compensated	Past history of visual field defect but currently 150° or more.	N/A
3.	Active impairment: a. Minimal b. Mild c. Moderate d. Severe	a. Binocular or monocular visual field of 140° or better. b. Binocular or monocular visual field of 140° or better with potential for deterioration. c. Peripheral vision of less than 140° but at least 110° Restricted to right and left outside mirrors. d. Permanent visual field of less than 110°	a. 4 years b. 1 year c. No driving d. No driving
4.	Condition under investigation	Recent onset of visual field loss.	As needed

* For further explanation refer to page 1

FUNCTIONAL ABILITY PROFILE: Visual Disorders
Visual Acuity

VISUAL ACUITY

1. Standard means visual test at the license renewal periods established by the Motor Vehicle statutes.
 2. Correction through the use of telescopic or bioptic lenses is not acceptable for purposes of meeting any of the visual acuity requirements nor may such lenses be used during any phase of the driver license examination process.
 3. The daytime only and/or geographic restriction(s) may be reduced or enlarged on the basis of:
 - a. a recommendation from an optometrist or ophthalmologist advising that the individual's vision is adequate to permit the safe operation of a motor vehicle; and
 - b. a supervisory driver's examination that demonstrates the individual's ability to operate a motor vehicle safely; and
 - c. a review of the individual's driving record shows the ability to operate a motor vehicle safely and in accordance with all applicable laws, rules, and regulations governing the operation of motor vehicles.
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