

**NOTICE OF PROPOSED GUIDANCE DOCUMENT**  
2019 Governors Pre-Conference MRU

Pursuant to Wis. Stat. s. 227.112, the Wisconsin Department of Transportation is hereby seeking comment on 2019 Governors Pre-Conference MRU, a proposed guidance document.

**PUBLIC COMMENTS AND DEADLINE FOR SUBMISSION**

Comments may be submitted to the Wisconsin Department of Transportation for 1 day by:

1. Department's

website: <https://trust.dot.state.wi.us/act369/?id=DMV985&uri=2019GovernorsPre-ConferenceMRU&division=DMV&tags=MRU>

2. Mailing written comments to:

Division of Motor Vehicles  
Wisconsin Department of Transportation  
4822 Madison Yards Way  
PO Box 7336  
Madison, WI 53707-7336

**WEBSITE LOCATION OF FINAL GUIDANCE DOCUMENT**

The final version of this guidance document will be posted at [wisconsin.gov](http://wisconsin.gov) to allow for ongoing comment.

**AGENCY CONTACT**

[DOTDMVGuidanceDocs@DOT.WI.GOV](mailto:DOTDMVGuidanceDocs@DOT.WI.GOV)

# Wisconsin Department of Transportation Division of Motor Vehicles

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Wisconsin's 45<sup>th</sup> Annual  
Governor's Conference on Highway Safety

August 20<sup>th</sup>, 2019

# Today's Agenda

- Introduction
- What is Medical Review & Fitness (MRF)?
- Making the Connections
- Most Common Conditions
- Federal Medical Cards (Fed Med)

# Introduction

- Supervisor
- Team Leader
- MVPS (Motor Vehicle Program Specialist)
- Processors (10)

# What is Medical Review & Fitness?

## Medical Forms

1. Vision
2. Neurological
3. Endocrine
4. General
5. Substance Abuse



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# Making The Connections

- Impact on Owners and Instructors



# Most Common Conditions

- Loss of Consciousness (End,Htn,Pulm)
- Seizures
- Driver Instructor Application

<b>Section B – Health Care Practitioner (please print)</b>					
Based on an examination conducted within the previous 24 months, please answer ALL of the following questions regarding the applicant on this form.					
		<b>Examination date:</b> _____		<b>(Required)</b>	
YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or other drug abuse or dependency within the past 12 months		Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date: _____		Loss of, or altered consciousness Date: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or other drug abuse or dependency within the past 12 – 24 months Controlled by treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Kidney disease, dialysis		Seizures, epilepsy Date: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive TB in a communicable form		Diabetes or elevated blood sugar controlled by <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin		Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or heart attack, stroke, other cardiovascular condition		Lung disease, emphysema, asthma, chronic bronchitis		Neuro/Muscular disease, e.g., ALS, MS, Head Trauma	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Required oxygen use		Blood pressure over 180/105	
				Missing or impaired hand, arm, foot, leg	
				Mental/Emotional Functions	
For any YES answers, indicate onset date, diagnosis, and any current limitations. List all medications (including over-the-counter medications) used regularly or recently. _____					

# Federal Medical Card



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# MRF/Physicians All Test

- Requirements
- Loss of Consciousness
- Seizure Disorder



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Questions?

