STATE OF MAINE
Department of Inland Fisheries and Wildlife
284 State Street, Station 41, Augusta, Me 04330

GUIDE'S MEDICAL EVALUATION

NAME_____

ADDRESS_____

_____

DATE OF BIRTH_____

NOTE: THIS IS THE ONLY FORM THAT WILL BE ACCEPTABLE TO THE DEPARTMENT OF INLAND FISHERIES & WILDLIFE.

(Exception) When military medical record or patient's hospital summary is submitted.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical history to the Commissioner, Department of Inland Fisheries and Wildlife, for the purpose of determining my eligibility for a Guide's License by Dr. _____or _____Hospital.

Signature of patient_____Date _____
(Please forward this form directly to your physician for completion.)

CERTIFICATE OF EXAMINATION

FOR THE REPORTING PHYSICIAN:

1. This report is requested because of the possibility that this applicant may have a mental/physical condition which could affect his/her ability to function as a licensed guide. The Authorization for Release of Medical Information will be retained by the Department of Inland Fisheries and Wildlife.

2. The Commissioner, by statute, is responsible for the licensing action. However, your report will be advisory and used to assist in determining eligibility for a license.

3. If you decline to complete this report, the Department of Inland Fisheries and Wildlife will require the applicant to obtain a certificate of examination from another physician of his/her choice.

Diagnoses 1. _____

2. _____

3. _____ Date of last examination_____

How long has this applicant been your patient?_____

Length of condition_____

Have signs and symptoms changed in past two years either in frequency so severity? If so, how and when? (If epilepsy, please give date of last seizure.)_____

Prognosis for reoccurrence or deterioration? Likely_____ Possible_____ Unlikely_____

Present medication, dosage and frequency: _____Reliability in taking medications:

No medication prescribed _____

Would the side effects from medications taken interfere with the safe operation of a motor vehicle, watercraft or firearm? _____

(over)

Has patient followed medical regimen closely? Present _____Past _____
Is patient likely to continue to follow medical regimen in future? _____

PHYSICIAN RECOMMENDATIONS

Yes	No	
_____	_____	Based on my examination, on the date indicated, I feel this patient has the mental and physical ability to operate a motor vehicle, watercraft and firearm safely.
_____	_____	Should the Department of Inland and Fisheries Wildlife have a medical evaluation each renewal?
_____	_____	Medically fit to function as a licensed guide.

COMMENTS / RECOMMENDATIONS:_____

_____

_____

_____

_____

Being duly licensed to practice I certify that I have examined this applicant.

_____ _____
Signature Classification or Specialty

_____ _____ _____
Medical License No. Office Phone No. Date