CERTIFICATE OF SUBSTANCE EXAMINATION BY COMPETENT AUTHORITY

MV3746 1/2013 Ch. 343 Wis. Stats. & Trans. 112 Admin. Code

APPLICANT: After this report has been reviewed, you may be required to file follow-up reports. We will send you the form at the required time.

Wisconsin Department of Transportation
Medical Review
PO Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

Applicant Name	Operator License Number
Street Address	Birth Date (m/d/yy)
City, State, ZIP Code	(Area Code) Telephone Number

Date Issued (m/d/yy)	Examiner Badge Number	License Type

☐ Instruction Permit ☐ Operator ☐ CDLI ☐ CDL ☐ School Bus ☐ Passenger Bus

Date of Assessment and/or report must be completed based on an examination conducted within the past 90 days or since _____ (m/d/yy)**.**

SECTION A

Assessment Findings: Please assess this client's dependency level on alcohol or controlled substances or other drugs. (check all that apply)

Date of Last Use/Abuse (m/d/yy)

☐ Irresponsible Use of Alcohol (IU)
☐ Irresponsible Use of Alcohol - Borderline (IUB)
☐ Suspected Alcohol Dependency
☐ Alcohol Dependency
☐ Alcohol Dependency in Remission
☐ Irresponsible Controlled Substance and/or Other Drug Use (IU)
☐ Irresponsible Use of a Controlled Substance and/or Other Drug Use
☐ Suspected Controlled Substance Dependency and/or Other Drug
☐ Controlled Substance and/or Other Drug Use Dependency
☐ Controlled Substance and/or Other Drug Use Dependency in Remission

Please check drinking pattern and chronicity for alcohol dependency or suspected alcohol dependency findings.

Drinking Pattern
☐ Intermittent ☐ Recurrent ☐ Steady

Chronicity
☐ Early ☐ Moderately Advanced ☐ Far Advanced

SECTION B

Treatment Recommended (check all that apply)

☐ No Treatment

☐ Driver is to abstain from all mood altering substances

☐ Outpatient Treatment: _____ (Regimen) _____ (Date Completed or Expected Completion – m/d/yy)

☐ Inpatient Treatment: _____ (Regimen) _____ (Date Completed or Expected Completion – m/d/yy)

☐ Aftercare: _____ (Regimen) _____ (Date Completed or Expected Completion – m/d/yy)

SECTION C

Is applicant currently compliant with recommended treatment?

☐ YES ☐ NO If NO, please explain:

X _____ (Counselor's Signature) _____ (Date Signed – m/d/yy)

_____ (Counselor's Title) _____ (Area Code – Office Telephone Number)

_____ (Office – Street Address, City, State, ZIP Code)