Pre-Owned Vehicle Test Drive Medical Disclosure Form

Date

Full Name

Phone Number

Email Address

Driverâ€™s License Number

Medical Information

Do you currently have any medical conditions that may impair your ability to safely operate a motor vehicle?

☐ No ☐ Yes

If yes, please provide details

Are you currently taking any medication that may affect your ability to drive?

☐ No ☐ Yes

If yes, please provide details

Are you experiencing any of the following symptoms today? (Check all that apply)

☐ Dizziness ☐ Blurred Vision ☐ Fatigue ☐ Shortness of Breath ☐ Other

If Other, please specify

Acknowledgement

I certify that the information provided above is accurate and complete to the best of my knowledge. I also acknowledge that I have disclosed any medical conditions or medications which may affect my ability to safely operate a motor vehicle during the test drive.

_____

Signature of Test Driver

_____

Date