NORTH KANSAS CITY
POLICE DEPARTMENT

City of North Kansas City
2010 Howell Street
North Kansas City, MO 64116

EXAMINATION TO DETERMINE PHYSICAL CONDITION OF TAXICAB DRIVERS

Driver's Name: ____
(Please Print) (Last) (First) (Middle)

☐ New Certification

Address: ____
(Number) (Street) (City) (State/Zip)

☐ Recertification

Date of Birth: ______________________ Age: __________

NOTE: This examination must be conducted by a medical doctor or doctor of osteopathic medicine.

Possession of a valid MEDICAL EXAMINER'S CERTIFICATE, stating that the applicant has been examined and passed such examination in accordance with FEDERAL MOTOR CARRIER SAFETY REGULATIONS 49 CFR 391.41 – 391.49, shall be deemed acceptable in lieu of a physical examination. Applicant must present a current MEDICAL EXAMINER'S CERTIFICATE to the POLICE DEPARTMENT when submitting application for a TAXICAB DRIVER'S PERMIT.

HEALTH HISTORY

YES	NO	
		Head or spinal injuries
		Seizures, fits, convulsions or fainting
		Extensive confinement by illness or injury
		Cardiovascular disease
		Tuberculosis
		Syphillis
		Gonorrhea
		Diabetes
		Suffering from any other disease
		Permanent defect from illness, disease or injury
		Psychiatric disorder
		Any other nervous disorder
		Gastrointestinal ulcer
		Nervous stomach
		Rheumatic fever
		Asthma
		Kidney disease
		Muscular disease

If answer to any of the above is yes, explain: ____

____

PHYSICAL EXAMINATION (When findings are normal, use check mark ✔ only)

General appearance and development: GOOD__________ FAIR__________ POOR__________ HEIGHT__________ WEIGHT__________

Vision: For distance: Right 20/______ Left 20/ ________ ☐Without corrective lenses ☐With corrective lenses if worn. Evidence of disease or injury: ______

Right __________________ Left __________________ Color Test __________________ Horizontal Field of Vision: __________________

Right __________________ Left__________________

Hearing: Right ear ______________ Left ear ________________ Disease or injury ________________

Thyroid: ____

Nose: ____________________ **Teeth:** ____________________ **Throat:** ____________________

Thorax: Heart: Abnormalities ______________________ Regularity ______________________

Murmurs: ______________________ If organic disease is present, is it fully compensated? ____________________

____

Blood Pressure: Systolic: ____________ Diastolic: ______________ Pulse: ______________________

Lungs: ______________________ Veins: ______________________ Arteries: __________________

Abdomen: Liver: ______________________ Kidney: ______________________ Spleen: ______________________

Hernia: ______________________ External Hemorrhoids: ______________________

Spine: Curvature: ______________________ Deformity: ______________________

Limitation of Motion: ____

Extremities: Amputation, Deformity, Limitation: Upper ____

Lower ____

Remarks ____

Genito-Urinary: Scars: ______________________ Urethral discharge: ______________________

Skin: ____

Nervous Stability: ____

Urinalysis: SP. GR. ________________ Reaction: ________________ Albumen: ________________ Sugar: ____________

Correctible Impairments: ____

Non-Correctible Impairments: ____

General Comments: ____

____

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined ______________________________ and with knowledge of his duties, I find him qualified to operate a taxicab.

☐ Qualified only when wearing corrective lenses ☐ Qualified only when wearing a hearing aid

A COMPLETED EXAMINATION FORM FOR THIS PERSON IS ON FILE IN MY OFFICE AT ______________________________
(Address) (Phone)

____
(Signature of Driver)

____
(Date of Examination) (Printed Name of Examining Doctor)

____
(Signature of Examining Doctor)