



# PHYSICIAN'S ASSESSMENT FORM

**The undersigned confirms that the patient named below:**

- 1. Requires vehicle modification to enable him/her to drive.
- 2. Requires vehicle modification to allow convenient access to enable him/her to transport a person with a disability.
- 3. Experiences a minimum 30 dB hearing loss in any frequency range and would therefore benefit from having an assistive alerting device installed in his/her new GM vehicle.

\_\_\_\_\_  
Physician's Name (Printed)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Patient's Name Signature

\_\_\_\_\_  
Date

**Please Note:**

- Please attach a copy of the physician's letterhead or copy this information on your physician's letterhead.
- As an alternative, please attach a prescription form to this document for confirmation of the physician's formal practice address and contact numbers.