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**COMMONWEALTH OF PENNSYLVANIA**
**DEPARTMENT OF TRANSPORTATION**
**Bureau of Driver Licensing**
**Mail Date: 09/14/2017**

JOSEPH F COTTER
1406 LINDEN LANE
WEST CHESTER PA 19380

Dear Mr. JOSEPH F COTTER:

This is an official **Notice of the Recall of your Driving Privilege** as authorized by Section 1519(c) of the Pennsylvania Vehicle Code. PennDOT has received medical information indicating you have a Diabetic and Neurological condition, which prevents you from safely operating a motor vehicle.

As of 09/21/2017, you may no longer drive. Your driving privilege is hereby recalled until you have demonstrated your condition meets PennDOT's minimum medical standards.

This decision has been made by comparing your medical information with the standards recommended by our Medical Advisory Board and adopted by PennDOT. This action will remain in effect until PennDOT receives medical information indicating that your condition has improved, and you are able to safely operate a motor vehicle. PennDOT may also require you to take and pass a driving examination before it will restore your driving privilege.

If you feel our records are incorrect, you may have your health care provider submit updated information detailing your medical condition.

In order to comply with the medical recall, you must return all valid Pennsylvania driver license products, including your driver's license, endorsement card, learner permits, temporary driver's license, and camera cards in your possession on or before the effective date listed above. If you cannot comply with the requirements stated above, a sworn affidavit stating you are aware of the action against your driving privilege must be submitted. When PennDOT receives all of your valid products or a sworn affidavit, you will be mailed a receipt. If you do not receive this receipt within 15 days, contact PennDOT's Driver and Vehicle Services Customer Care Center at 1-800-932-4600 immediately.

If you do not return all current driver's license products, this matter will be referred to the Pennsylvania State Police for prosecution under Section 1571 (a) (4) of the Pennsylvania Vehicle Code.

**YOU MAY NOT RETAIN YOUR DRIVER'S LICENSE FOR IDENTIFICATION PURPOSES.** However, you may apply for and obtain a free photo identification card. The initial issuance of the photo identification card will be free by completing and following the instructions on the Application for Initial Photo Identification Card (DL-54A), which is available on PennDOT's Driver and Vehicle Services website at **www.dmv.pa.gov.** The photo identification card will be valid for four years; however, you will be required to pay the renewal fee after the initial issuance, if you wish to continue to hold a photo identification card.

You have the right to appeal to the Court of Common Pleas (Civil Division) within thirty (30) days of the mail date of this notice. If you file an appeal in the County Court, the Court will give you a time-stamped certified copy of the appeal. In order for your appeal to be valid, you must send this time-stamped certified copy of the appeal by certified mail to:

Pennsylvania Department of Transportation
Office of Chief Counsel
1101 South Front Street
Third Floor, Riverfront Office Center
Harrisburg, PA 17104

You still must send in your Pennsylvania driver's license products by the effective date of recall unless you appear in person before a judge and receive an order permitting you to continue driving.

If you have any questions, please contact PennDOT's Medical Unit at (717) 787-9662, Monday through Friday, between the hours of 8:00 a.m. and 4:15 p.m.

Sincerely,

Kara N. Templeton, Director
Bureau of Driver Licensing

Driver License # 22352044
Enclosures: DL-122:Diabetic Form
DL-124:General Neurologic Form

DL-124 (8-16)

pennsylvania
DEPARTMENT OF TRANSPORTATION

# GENERAL NEUROLOGICAL FORM

**PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION**

Bureau of Driver Licensing • P.O. Box 68682 • Harrisburg, PA 17106-8682 • (717) 787-9662

**THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/17/2015**

**Provider: For more information relating to Medical Reporting, visit www.dmv.pa.gov and click on the Medical Reporting tab under Information Centers.**

## PATIENT INFORMATION (Please complete this form in its entirety)

| DRIVER'S LICENSE NUMBER | LAST NAME(S) | JR. ETC | FIRST NAME |
|---|---|---|---|
| 22352044 | COTTER | | JOSEPH |

| HEIGHT | | SEX | EYE COLOR | DATE OF BIRTH | | | TELEPHONE NUMBER | E-MAIL (IF APPLICABLE) |
|---|---|---|---|---|---|---|---|---|
| FEET | INCHES | | | MONTH | DAY | YEAR | | |
| | | | | | | | | |

| STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address. | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

1. How long have you been treating the patient? _____

2. Has the patient been diagnosed with a cerebral vascular insufficiency? ❑ YES ❑ NO

3. Has the patient had any of the following disqualifying episodes as a result of cerebral vascular insufficiency? ❑ YES ❑ NO

   a. ❑ **Syncopal Attack** - Date of last episode _____

   b. ❑ **Loss of Consciousness** - Date of last episode _____

   c. ❑ **Vertigo** - Date of last episode _____

   d. ❑ **Paralysis** - Date of last episode _____

   e. ❑ **Loss of qualifying visual fields** - Date of last episode _____

4. Does the patient have impairment in any of the following areas?

   a. Reaction time? ❑ YES ❑ NO

   b. Coordination of movement of the extremities? ❑ YES ❑ NO

   c. Muscular strength? ❑ YES ❑ NO

5. Does the patient have excessive aggressiveness or disregard for the safety of self or others? ❑ YES ❑ NO

6. Does the patient have any cognitive impairment(s) including but not limited to attentiveness to the task of driving, judgement and problem solving, planning and sequencing, visuospatial perception and or memory? ❑ YES ❑ NO

7. Do any yes answers above indicate that the customer should cease driving immediately? ❑ YES ❑ NO

8. Is the patient being treated with medicine? ❑ YES ❑ NO

9. Does the medication(s) make the patient unsafe to drive? ❑ YES ❑ NO

   If yes, please specify _____

## HEALTH CARE PROVIDER INFORMATION (Please print or type)

| HEALTH CARE PROVIDER'S NAME | SPECIALTY | HEALTH CARE PROVIDER'S LICENSE NUMBER |
|---|---|---|
| | | |

| STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| TELEPHONE NUMBER | FAX NUMBER |
|---|---|
| | |

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ Health Care Provider's Signature

_____ Date

DL-122 (9-15)

pennsylvania
DEPARTMENT OF TRANSPORTATION

# DIABETIC FORM

Bureau of Driver Licensing, P.O. Box 68682, Harrisburg, PA 17106-8682, (717) 787-9662

**THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12**

**Provider: For more information relating to Medical Reporting, visit www.dmv.pa.gov and click on the Medical Reporting tab under Information Centers.**

## PATIENT INFORMATION (Please complete this form in its entirety unless otherwise noted)

| DRIVER'S LICENSE NO. | LAST NAME(S) | JR. ETC | FIRST NAME |
|---|---|---|---|
| 22352044 | COTTER | | JOSEPH |

| HEIGHT | | SEX | EYE COLOR | DATE OF BIRTH | | | TELEPHONE NUMBER |
|---|---|---|---|---|---|---|---|
| FEET | INCHES | | | MONTH | DAY | YEAR | ( ) |
| | | | | | | | |

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.

| CITY | STATE | ZIP CODE |
|---|---|---|
| | | |

1. How long have you been treating the patient? _____
2. Do you treat the patient on a regular basis? _____
3. Has the patient been diagnosed with diabetes mellitus? _____

**PLEASE NOTE: IF PATIENT HAS BEEN DIAGNOSED WITH DIABETES, PAGE 2 OF THIS FORM MUST BE COMPLETED.**

4. Has the patient been diagnosed with unstable diabetes mellitus? _____

   If yes, please continue. If no, you may move on to complete page 2.

   a. Within the past 6 months, has it led to severe hypoglycemic reaction(s) that required outside intervention or assistance of others or that produced confusion, loss of attention or a loss of consciousness? _____

   If yes, date of episode(s): _____

   b. Within the past 6 months, has it led to symptomatic hyperglycemia, which caused a loss of consciousness or an altered state of perception, including, but not limited to, decreased reaction time, impaired vision or hearing, or both, and confusion? _____ If yes, date of episode(s): _____

   c. If yes, did the episode(s) occur while under a health care provider's supervision? _____

   d. If yes, did the episode(s) occur during or concurrent with a nonrecurring transient illness, toxic ingestion or metabolic imbalance? _____

   e. If yes, was the episode(s) caused by a temporary condition or isolated incident that is not likely to recur? _____

5. Is the patient being treated with medication? _____

   If yes, type: _____ dosage: _____

6. What were the results of the patient's most recent HbA1C screening? _____ date of test : _____

## HEALTH CARE PROVIDER INFORMATION (Please print or type)

| HEALTH CARE PROVIDER'S NAME | SPECIALTY | HEALTH CARE PROVIDER'S LICENSE NUMBER | |
|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP CODE |
| TELEPHONE NUMBER ( ) | FAX NUMBER ( ) | | |

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C. S. §4904 (relating to unsworn falsification to authorities). Punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ Health Care Provider's Signature

_____ Date

DL-122 (9-15)

Patient Name COTTER Driver's License Number 22352044

**REGULAR DRIVER (CLASS A, B, C & M)**

| UNCORRECTED |
|---|
| R 20/ |
| L 20/ |
| B 20/ |

| CORRECTED |
|---|
| R 20/ |
| L 20/ |
| B 20/ |

1. Please indicate individual's visual acuity by marking the appropriate box:

   ❑ A. Combined vision is 20/40 or better. . . .With Correction❑ W/O Correction❑

   ❑ B. Combined vision is poorer than 20/40 but has been corrected to 20/60 or better.

   ❑ C. Combined vision is poorer than 20/60 but has been corrected to at least 20/70.

   a) Do you consider this person visually capable to drive?. . . . Yes❑ No❑

   ❑ D. Combined vision is poorer than 20/70 and not correctable to 20/70.

| | CHECK ONE: YES | NO |
|---|---|---|
| 2. Is individual's combined field of vision at least 120° in the horizontal meridian, excepting the normal blind spots? | ❑ | ❑ |
| 3. Does individual have better than 20/100 vision in each eye with correction? | ❑ | ❑ |
| 4. Must individual wear corrective lenses? | ❑ | ❑ |
| 5. Does this individual no longer require corrective lenses as a result of corrective surgery? | ❑ | ❑ |
| 6. Is correction obtained through telescopic lenses? | ❑ | ❑ |
| 7. Did this individual have a dilated eye exam? | ❑ | ❑ |

Date of last dilated eye exam: _____

## HEALTH CARE PROVIDER INFORMATION (Please print or type)

| HEALTH CARE PROVIDER'S NAME | SPECIALTY | HEALTH CARE PROVIDER'S LICENSE NUMBER | |
|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP CODE |
| TELEPHONE NUMBER ( ) | FAX NUMBER ( ) | | |

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C. S. §4904 (relating to unsworn falsification to authorities). Punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ Health Care Provider's Signature

_____ Date