



Applications must be submitted to Service SA in country regions or to Accreditation and Licensing Centre in the Adelaide Metropolitan Area.

Enquiries Telephone: 13 10 84
Complex Enquiries Telephone: (08) 8226 8026
Website: www.sa.gov.au/transportindustry
E-mail: dtei.alcenquiries@sa.gov.au

ABN: 92 366 288 135

Guidelines for completing form

Applicant must:

- make an appointment with his or her regular treating doctor;
complete Section 1 on this page prior to the medical examination;
bring to the examination any spectacles, hearing aids or similar items that you use.

The doctor may extend the examination where considered clinically appropriate, but must advise the applicant of any extra cost.

Payment for the examination is not the responsibility of Department for Transport, Energy and Infrastructure (DTEI) and is not usually rebatable under Medicare.

Section 1 – Applicant to Complete:

Please answer the questions by ticking the correct box. If you are not sure, clarify with the doctor who will ask you additional questions during the examination. Include details on a separate sheet if necessary.

Form section containing questions 1-11 with 'No' and 'Yes' columns. Questions cover medical history, accidents, and specific conditions like high blood pressure and diabetes.

Form section containing questions 6.12-6.19, 7, 8, 9, 10, and 11 with 'No' and 'Yes' columns. Questions cover vision issues, psychiatric illness, alcohol consumption, and drug use.

12. Applicant's Declaration:

I, [Signature Line]

Driver Accreditation Number: [Box] Telephone Number: ( ) [Box]

(a) declare that to the best of my knowledge the information regarding my medical background is true and correct and that I have made the Doctor aware of any medical conditions which I may have and drugs or medication that I use;
(b) consent that the doctor who signed the reverse of this form may release my medical information to DTEI, or a medical practitioner nominated by DTEI, in order to assess my medical eligibility for driver accreditation.

Signature: [Signature Line] Date: / /

(in the presence of Medical Practitioner)

