Mike DeWine, Governor
Thomas J. Stickrath, Director

- **Bureau of Motor Vehicles**
- Emergency Management Agency
- Emergency Medical Services
- Office of Criminal Justice Services
- Ohio Homeland Security
- Ohio State Highway Patrol

Donald J. Petit
Registrar

Bureau of Motor Vehicles
1970 West Broad Street
P.O. Box 16520
Columbus, Ohio 43216-6520
(614) 752-7600
www.bmv.ohio.gov

Dear Physician:

This patient has been referred to you because he or she has applied for enrollment in the State of Ohio's Motorcycle Ohio program. The person presenting the Release & Waiver and Request for Statement of Physician forms, has stated that they have a pre-existing medical condition that may affect their ability to operate a motorcycle. This program involves basic skills training on a small motorcycle operated on a riding range. The training is supervised by licensed Motorcycle Ohio instructors.

To properly verify the medical condition of the applicant, we require a physician's statement diagnosing any health conditions or concerns for this patient, and verifying that, based upon your assessment of his/her medical conditions, this applicant is capable of participating in the Motorcycle Ohio Program. Your careful evaluation of the applicant's health and any conditions or concerns affecting the applicant’s ability to participate in this type of training may prevent injuries to the patient, our staff and others involved with the course.

Your prompt completion of the physician's statement will prevent any delay in our informing the applicant of whether or not he/she will have the opportunity to participate in the program.

PLEASE DO NOT COMPLETE THE FORM UNTIL THE APPLICANT HAS SIGNED AND DATED THE RELEASE OF THE INFORMATION SECTION.

Thank you for your cooperation.

Sincerely,

Motorcycle Ohio

Mission Statement
“to save lives, reduce injuries and economic loss, to administer Ohio’s motor vehicle laws and to preserve the safety and well being of all citizens with the most cost-effective and service-oriented methods available.”

WAIVER AND RELEASE
FOR
PARTICIPANTS WITH MEDICAL CONDITIONS

The undersigned participant, and his parent or legal guardian, if the participant is under the age of eighteen (18), acknowledges that he has a medical condition which may affect his ability to safely operate a motorcycle in the Motorcycle Ohio program. (For example, asthma, epilepsy, or any disability which may affect his ability to operate a motorcycle) In consideration of permission to participate in the Motorcycle Ohio Program, the participant does hereby execute this waiver and release for himself, his heirs, successors, his representatives, and assigns and hereby agrees and represents as follows:

To release the Sponsor and its employees, the Department of Public Safety and the State of Ohio and any employees or agents of the Department of Public Safety and/or the State of Ohio, and any other organizations affiliated with this course from any and all liability, loss, damage, costs, claims, and/or courses of action, including but not limited to, all bodily injuries and property damage arising out of the course referred to above. It is specifically understood that the participant voluntarily assumes the risk of any injury to himself or herself, to others or to any property while participating in the Motorcycle Ohio Program, in spite of the aforementioned medical condition.

The undersigned further agrees to hold THE STATE OF OHIO, DEPARTMENT OF PUBLIC SAFETY'S MOTORCYCLE OHIO PROGRAM AND SPONSOR, its members, employees, agents and representatives harmless for any liability loss, damage, costs, claims result of the undersigned's participation in said course. The release from liability shall include liability for attorney's fees incurred in defending against any claim or judgment and incurred in negotiating any settlement. It is understood and agreed that the undersigned shall have the opportunity to consent to any such settlement, provided, however, that such consent shall not be unreasonably withheld; The undersigned further states: (1) that he/she is aware of the fact that the aforesaid activity is an inherently dangerous activity, that (2) he/she assumes the risk of any injury while participating in such activity, that (3) he she is of legal age and is competent to sign this waiver and release, or that he/she is less than 18 years of age and this release is signed by his/her parent or legal guardian; and (4) that he/she has read and understood all the provisions contained herein.

The release and waiver form must be signed prior to the beginning of the course. If you are 15 ½ -17 years old, this form must either be signed in the presence of the course instructor by a parent or legal guardian or must be notarized.

SIGNATURE OF PARTICIPANT **X**	DATE
SIGNATURE OF PARENT OR GUARDIAN IF PARTICIPANT IS UNDER 18 **X**	RELATIONSHIP

State of Ohio

County of ________________ ,SS:______________________

The foregoing instrument was acknowledged before me this ____________ day of ______________________ , 20 ______ , by.

X ________________________________ and **X** ________________________________

STUDENT PARENT OR LEGAL GUARDIAN

My commission expires ________________ , 20 ___________ **X** ________________________________

NOTARY PUBLIC

***NOTE A medical statement from a physician licensed in this state pursuant to Ohio Revised Code Chapter 4731, must be submitted along with this form in order to participate in the Motorcycle Ohio Program.**

OHIO DEPARTMENT OF PUBLIC SAFETY

REQUEST FOR STATEMENT OF PHYSICIAN

Patient Information: Please type or print in ink

STUDENTS NAME - LAST	FIRST	MIDDLE
ADDRESS		
CITY	STATE	ZIP
DRIVER LICENSE #		DATE OF BIRTH

I hereby authorize and request information regarding my physical and mental condition be released to the Ohio Department of Public Safety.

SIGNATURE OF PARTICIPANT **X**	DATE
SIGNATURE OF PARENT OR GUARDIAN IF PARTICIPANT IS UNDER 18 **X**	RELATIONSHIP

☐ **New Patient** ☐ **Patient previously seen by me**

Patient's history and/or physical examination reveals the following:	**Yes**	**No**
1. Vision abnormalities or eye disease (not corrected by eyeglasses)	☐	☐
2. Skeletal defects (including any loss of limb)	☐	☐
3. Cardiovascular disease (e.g., strokes, angina, heart failure, hypertension)	☐	☐
4. Respiratory disease (e.g., emphysema, asthma)	☐	☐
5. Metabolic disease (e.g., diabetes, hypoglycemia, myasthenia gravis)	☐	☐
6. Neurological (e.g., epilepsy, multiple sclerosis, Parkinson's disease)	☐	☐
7. Abuse of alcohol or drugs	☐	☐
8. Mental illness	☐	☐
9. Other illness of questionable etiology (e.g., fainting, blackout)	☐	☐

Briefly explain "yes" answers above:

	Years	Months
How long has the condition been continuously under control without an episode or reaction?		

	Yes	No
Is medication prescribed?	☐	☐
If prescribed, does the medication or combination of medications ordinarily impair functions of the patient that would interfere with his/her driving a motorcycle?	☐	☐
If continued medication is recommended, in your opinion can the patient be depended upon to take this medication as prescribed?	☐	☐
In your professional opinion, is the patient's condition(s) now under medical control to allow reasonable and ordinarily control in the operation of a motorcycle?	☐	☐

NAME OF PHYSICIAN (PLEASE PRINT)		
PHYSICIAN'S SIGNATURE **X**		DATE
ADDRESS		CITY
STATE	ZIP	PHONE

The Request for Statement of Physician form must be signed prior to the beginning of the course. If you are 15 ½ -17 years old, this form must either be signed in the presence of the course instructor by a parent or legal guardian or must be notarized.

SIGNATURE OF PARTICIPANT **X**	DATE
SIGNATURE OF PARENT OR GUARDIAN IF PARTICIPANT IS UNDER 18 **X**	RELATIONSHIP

State of Ohio

County of _________________ ,SS:________________________

The foregoing instrument was acknowledged before me this ______________day of _______________________ , 20 ______ , by.

X ______________________________ and **X** ______________________________

STUDENT PARENT OR LEGAL GUARDIAN

My commission expires __________________ , 20 ____________ **X** ______________________________

NOTARY PUBLIC

***NOTE A medical statement from a physician licensed in this state pursuant to Ohio Revised Code Chapter 4731, must be submitted along with this form in order to participate in the Motorcycle Ohio Program.**