ATTACHMENT D
Applicant with Seizure Disorders

Name of Applicant: _____

Name of Licensed Physician: _____

Date Completed: _____

1. In what capacity do you know the applicant?

   _____

   _____

2. How long have you known or worked with the applicant?

   _____

   _____

3. When did you last see the applicant?

   _____

   _____

4. Please describe what the applicant experiences during and after a seizure.

   _____

   _____

5. How often do seizures occur?

   _____

   _____

6. What is the prognosis?

   _____

   _____

7. Are the seizures preceded by an aura?

   ❑ Yes ❑ No ❑ Sometimes

   _____

   _____

8. If Yes or Sometimes, does the applicant usually have time to prepare and make himself/herself as safe as possible?

9. Are there certain things that will trigger the applicant's seizures?

❑ Yes ❑ No

Comments:

10. If Yes, please describe these triggers.

11. Please describe the applicant's ability to travel alone in the community. When and where can he/she safely travel?

12. What advise or limitation on traveling alone in the community have been communicated to the applicant?

13. Is the applicant permitted to drive?

❑ Yes ❑ No

Comments:

14. Is the applicant taking any medication(s) prescribed by you or another professional?

❑ Yes ❑ No

Comments:

15. If Yes, please list the type, frequency, dose and any comments about how the medication(s) may complicate the individual's independent mobility in the community?

Medication Type	Dosage	Effect on Functional Ability (if any)
General Manager		

16. If the applicant takes his/her medication compliantly, will he/she be able to travel independently in the community?

❑ Yes ❑ No

Comments: _____

17. Do you deem the applicant to be compliant in taking prescribed medication?

❑ Yes ❑ No

Comments: _____

18. Is there anything about the use of medication that would complicate the individual's use of public transportation?

❑ Yes ❑ No

If Yes, please explain: _____

19. Has the applicant functional ability decreased temporarily due to adjustment to medication?

❑ Yes ❑ No

20. If Yes, please explain and note the expected duration of the decrease in functional ability.

_____

_____

21. Comments about the applicant's typical activities and current travel destinations.

_____

_____

PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW

Signature: _____ Date: _____

Print Name & Title: _____

Ethnic Origin:

Current Guam Medical License No. _____

Business Address: _____

_____

Mailing Address: _____

_____

Telephone No: _____ Fax No. _____