SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	9/28/16
Sub-section	Infection Control		
Policy	Reportable Diseases, Conditions and Occurrences	**Last Revised:**	9/28/16
Policy #			
Director's Approval	Alice Gleghorn, PhD	**Date**	
PHF Medical Director's Approval	Leslie Lundt, MD	**Date**	
Supersedes:	Unusual Occurrence and Reportable Disease Protocol	**Audit Date:**	9/28/19

1. PURPOSE/SCOPE

1.1. To comply with the California Code of Regulations, Title 17 Section 2500.

1.2. Responsibility for reporting includes but is not limited to: physicians; infection prevention and control practitioners; physician assistants; nurse practitioners; nurses; or anyone having knowledge of a reportable condition.

2. POLICY

2.1. The Psychiatric Health Facility (PHF) will comply will all relevant state and federal laws and regulations regarding reporting of diseases, conditions and occurrences as required by the Santa Barbara County Public Health Department (PHD).

3. STANDARDS

3.1. The form used for reporting to the Santa Barbara County PHD is the *Communicable Disease – (Except Tuberculosis) Confidential Morbidity Report (CMR)* form (see Attachment A).

3.2. The list of diseases, conditions and the required form for reporting is attached to this policy. A diagnosis or a suspected case of any of the diseases or conditions, as listed in *Reportable Disease* form (see Attachment B), must be reported to PHD within the designated timeframe.

3.3. Tuberculosis will be reported using the *Tuberculosis Confidential Morbidity Report* (see Attachment C).

3.4. The *Communicable Disease Confidential Morbidity Report (CMR)* and the *Tuberculosis Confidential Morbidity Report* forms are faxed to the respective numbers at the Santa Barbara County Public Health Department. The fax numbers are on the forms.

3.5. AIDS/HIV cases are telephoned to the Disease Control Office phone number listed on the front of either *Confidential Morbidity Report* forms.

3.6. Conditions impairing the ability to drive must be reported via the *Department of Motor Vehicles Conditions Impairing Driving Capacity* form (see Attachment D).

ASSISTANCE

Charlotte Balzer-Gott, RN PHF Nursing Supervisor

Charlotte Elise McKee, MSN, PHN, RN, CIC

REFERENCE

California Code of Regulations Title 17 Section 2500

ATTACHMENTS

Attachment A – *Communicable Disease – (Except Tuberculosis) Confidential Morbidity Report*

Attachment B – *Reportable Diseases and Conditions*

Attachment C – *Tuberculosis Confidential Morbidity Report*

Attachment D – *Department of Motor Vehicles (Conditions Impairing Driving Capacity) Confidential Morbidity Report*

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

Attachment A

State of California—Health and Human Services Agency

Communicable Diseases-(Except Tuberculosis)

California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | **First Name** | **MI**

Home Address: Number, Street | **Apt./Unit No.**

City | **State** | **ZIP Code**

Home Telephone Number | **Cell Telephone Number** | **Work Telephone Number**

Email Address | **Primary Language** ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | **Age** ☐ Years ☐ Months ☐ Days | **Gender** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | **Est. Delivery Date** (mm/dd/yyyy) | **Country of Birth**

Occupation or Job Title | **Occupational or Exposure Setting (check all that apply):** ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian (check all that apply)
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other (specify): _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander (check all that apply)
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other (specify): _____

☐ White
☐ Other (specify): _____
☐ Unknown

Date of Onset (mm/dd/yyyy) | **Date of First Specimen Collection** (mm/dd/yyyy) | **Date of Diagnosis** (mm/dd/yyyy) | **Date of Death** (mm/dd/yyyy)

Reporting Health Care Provider | **Reporting Health Care Facility**

Address: Number, Street | **Suite/Unit No.**

City | **State** | **ZIP Code**

Telephone Number | **Fax Number**

Submitted by | **Date Submitted** (mm/dd/yyyy)

REPORT TO:

SANTA BARBARA COUNTY
PUBLIC HEALTH

Disease Control Office

PHONE: (805) 681-5280
FAX: (805) 681-4069

(Obtain additional forms from your local health department.)

Laboratory Name | **City** | **State** | **ZIP Code**

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** (mm/dd/yyyy)

☐ **Untreated**
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
- ☐ RPR ☐ Pos ☐ Neg ____
- ☐ VDRL ☐ Pos ☐ Neg ____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg ____
- ☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) (check all that apply)
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply)
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: ____ Upper Limit: ____
AST (SGOT) Result: ____ Upper Limit: ____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

CDPH 110a (1/11) (for reporting all conditions except Tuberculosis and conditions reportable to DMV) Page 1

Attachment B

Santa Barbara County • Public Health Department • Disease Control

345 Camino del Remedio, Room 338, Santa Barbara, CA, 93110
PHONE: (805) 681-5280 • FAX: (805) 681-4069 • WEB: http://www.sbcphd.org /DCP

Urgent Reporting Requires submittal of CMR via the CalREDIE Provider Portal AND the following:

☎ = Report immediately by telephone.
✉ = Report by telephone within 1 working day of identification.
⑦ = Report within 7 calendar days from the time of identification.

REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641-2643, and §2800-2812

- ✉ Amebiasis
- ⑦ Anaplasmosis
- ☎ Anthrax (Human or Animal)
- ✉ Babesiosis
- ☎ Botulism (Infant, Foodborne, Wound, Other)
- ⑦ Brucellosis (Animal, except Brucella canis)
- ☎ Brucellosis (Human)
- ✉ Campylobacteriosis
- ⑦ Chancroid
- ✉ Chicken Pox (outbreaks, hospitalization, deaths) (Do not report cases of herpes zoster/shingles)
- ⑦ Chlamydia trachomatis infections, including Lymphogranulom Venereum (LGV)
- ✉ Chikungunya Virus Infection
- ☎ Cholera
- ☎ Ciguatera Fish Poisoning
- ⑦ Coccidioidomycosis
- ⑦ Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- ✉ Cryptosporidiosis
- ⑦ Cyclosporiasis
- ⑦ Cysticercosis or Taeniasis
- ☎ Dengue Virus Infection
- ☎ Diphtheria
- ☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- ⑦ Ehrlichiosis
- ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ☎ ***Escherichia coli*** : shiga toxin producing (STEC) Including E. coli O157
- ☎ Flavivirus infection of undetermined species
- ✉ Foodborne Disease: (2 or more cases from separate households with same suspected source)
- ⑦ Giardiasis
- ⑦ Gonococcal Infections
- ✉ ***Haemophilus influenzae***, invasive disease, all sertotypes (<5 years only)
- ✉ Hantavirus Infections
- ☎ Hemolytic Uremic Syndrome

Hepatitis:
- ✉ Hepatitis A (Acute infection)
- ⑦ Hepatitis B (specify acute case or chronic)
- ⑦ Hepatitis C (specify acute case or chronic)
- ⑦ Hepatitis D (Delta – specify Acute or Chronic)
- ⑦ Hepatitis E, Acute Infection

- ⑦ Human Immunodeficiency Virus (HIV) ♠
- ☎ Human Immunodeficiency Virus (HIV), acute ♠
- ⑦ Human Immunodeficiency Virus (HIV), stage 3 (AIDS) ♠
- ⑦ Influenza (ICU or Death – Lab Confirmed 0-64 yrs old)
- ⑦ Influenza (Human – Novel Strain)
- ⑦ Legionellosis
- ⑦ Leprosy (Hansen's Disease)
- ⑦ Leptospirosis
- ✉ Listeriosis
- ⑦ Lyme Disease
- ✉ Malaria
- ☎ Measles (Rubeola)
- ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ☎ Meningococcal Infections
- ⑦ Mumps
- ☎ Novel Virus Infection with Pandemic Potential
- ☎ Paralytic Shellfish Poisoning
- ✉ Pertussis (Whooping Cough)
- ☎ Plague, Human or Animal
- ✉ Poliovirus Infection
- ✉ Psittacosis
- ✉ Q Fever
- ☎ Rabies, Human or Animal
- ✉ Relapsing Fever
- ⑦ Respiratory Syncytial Virus (only report a death in a patient less than five years of age)
- ⑦ Rickettsial Disease (non-Rocky Mountain Spotted Fever), including Typhus and Typhus like Illnesses)
- ⑦ Rocky Mountain Spotted Fever

Rubella:
- ⑦ Rubella (German Measles)
- ⑦ Rubella Syndrome, Congenital

- ✉ Salmonellosis (Other than Typhoid Fever)
- ☎ Scombroid Fish Poisoning
- ☎ Shiga toxin (detected in feces)
- ✉ Shigellosis
- ☎ Smallpox (Variola)

Streptococcal Infections:
- ✉ Outbreaks of any type
- ✉ Individual case in a food handler
- ✉ Individual case in a dairy worker

- ✉ Syphilis
- ⑦ Tetanus
- ✉ Trichinosis
- ✉ Tuberculosis
- ⑦ TST Reactors (age <3 years only) ✱
- ⑦ Tularemia (Animal)
- ☎ Tularemia (Human)
- ✉ Typhoid Fever, Cases and Carriers
- ✉ *Vibrio* Infections
- ☎ Viral Hemorrhagic Fevers – Human/Animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
- ✉ West Nile Virus (WNV) Infection
- ☎ Yellow Fever
- ✉ Yersiniosis
- ☎ Zika Virus Infection

☎ **OCCURRENCE OF ANY UNUSUAL DISEASE** (including diseases not listed in §2500. Specify if institutional and/or open Community)

☎ **OUTBREAKS OF ANY DISEASE**

♠HIV Reporting by Health Care Providers
§2641.5-2643.20. Send HIV/AIDS reports via FedEx, UPS or direct courier to:
HIV/AIDS Services
300 N. San Antonio Road, Room A110
Santa Barbara, CA 93110
Phone: (805) 681-5361

✱**Local Surveillance**

REPORTABLE NON-COMMUNICABLE DISEASES AND CONDITIONS

Conditions Impairing Driving Capacity (pursuant to H&S 103900)
Lapses of consciousness or control. Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely.

It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed above, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report. "Health care provider" encompasses physicians, surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, dentists and chiropractors.

This updated list reflects reportable diseases and conditions as of 06/2016

HCS-788 (06/2016)

Attachment C

State of California—Health and Human Services Agency

Tuberculosis

California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis.

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address | Primary Language ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian (check all that apply)
☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese
☐ Chinese ☐ Korean ☐ Other (specify): _____
☐ Filipino ☐ Laotian
☐ Pacific Islander (check all that apply)
☐ Native Hawaiian ☐ Samoan
☐ Guamanian ☐ Other (specify): _____
☐ White
☐ Other (specify): _____
☐ Unknown

Date of Onset (mm/dd/yyyy) | Date of First Specimen Collection (mm/dd/yyyy) | Date of Diagnosis (mm/dd/yyyy) | Date of Death (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility

Address: Number, Street | Suite/Unit No.

City | State | ZIP Code

Telephone Number | Fax Number

Submitted by | Date Submitted (mm/dd/yyyy)

Laboratory Name | City | State | ZIP Code

REPORT TO:

SANTA BARBARA COUNTY
PUBLIC HEALTH

Disease Control Office

PHONE: (805) 681-5280
FAX: (805) 681-4069

(Obtain additional forms from your local health department.)

TUBERCULOSIS (TB)

Status
☐ Active Disease
☐ Confirmed
☐ Suspected
☐ Infected, No Disease
☐ Converter*

* For TST, an increase of ≥10 mm in induration size during ≤2 years

☐ Reactor Age <3 yrs

Sites(s)
☐ Pulmonary
☐ Extra-Pulmonary
☐ Both

Mantoux TB Skin Test

Date Placed (mm/dd/yyyy) _____ Date Read (mm/dd/yyyy) _____

Results: _____ mm ☐ Not done ☐ Pending ☐ Not read

Interferon Gamma Release Assay (IGRA)

Date Collected: _____ (mm/dd/yyyy)

Specify test name: _____

Results: ☐ Positive ☐ Not done ☐ Indeterminate ☐ Unknown ☐ Negative

Imaging: ☐ Chest X-Ray ☐ Chest CT Scan or Other Chest Imaging Study

Date Performed: _____ (mm/dd/yyyy)

Results: ☐ Normal ☐ Pending ☐ Cavitary ☐ Abnormal/Noncavitary ☐ Not done

Bacteriology/Pathology

Please mark positive on smear or culture if any of initial specimens obtained was positive

Date Specimen Collected: _____ (mm/dd/yyyy)

Source: _____

Smear for acid-fast bacilli:
☐ Pos ☐ Neg ☐ Pending ☐ Not done

Culture for *M. tuberculosis* complex:
☐ Pos ☐ Neg ☐ Pending ☐ Not done

Pathology suggests TB ☐

Rapid Drug Resistance Assay
☐ INH resistance ☐ Not done
☐ RIF resistance
☐ No INH or RIF resistance detected

Nucleic Acid Amplification/PCR Test for *M. tuberculosis* complex

Specify test type: _____

Results: ☐ Pos ☐ Indeterminate ☐ Neg ☐ Not done

Other test(s): _____

TB TREATMENT INFORMATION

☐ **Current Treatment** (check all that apply)
☐ INH ☐ RIF ☐ PZA
☐ EMB
☐ Other: _____
☐ Other: _____
☐ Other: _____

Date Treatment Initiated: _____ (mm/dd/yyyy)

☐ **Drug resistance suspected**

☐ **Untreated**
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Other: _____
☐ Referred to: _____

Remarks:

CDPH 1106 (1/11) (for reporting Tuberculosis) Page 1

Attachment D

State of California—Health and Human Services Agency California Department of Public Health

Department of Motor Vehicles - (Conditions Impairing Driving Capacity)

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting lapses of consciousness or control, Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely (persuant to H&S 103900).

CONDITION BEING REPORTED

Patient Name - Last Name | **First Name** | **MI**

Home Address: Number, Street | **Apt./Unit No.**

City | **State** | **ZIP Code**

Home Telephone Number | **Cell Telephone Number** | **Work Telephone Number**

Email Address | **Primary Language** ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | **Age** ☐ Years ☐ Months ☐ Days | **Gender** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | **Est. Delivery Date** (mm/dd/yyyy) | **Country of Birth**

Occupation or Job Title | **Occupational or Exposure Setting (check all that apply):** ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Date of Onset (mm/dd/yyyy) | **Date of First Specimen Collection** (mm/dd/yyyy) | **Date of Diagnosis** (mm/dd/yyyy)

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian (check all that apply)
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other (specify):
- ☐ Filipino ☐ Laotian

☐ Pacific Islander (check all that apply)
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other (specify): _____

☐ White
☐ Other (specify): _____
☐ Unknown

Reporting Health Care Provider | **Reporting Health Care Facility**

Address: Number, Street | **Suite/Unit No.**

City | **State** | **ZIP Code**

Telephone Number | **Fax Number**

Submitted by | **Date Submitted** (mm/dd/yyyy)

REPORT TO:

SANTA BARBARA COUNTY
PUBLIC HEALTH

Disease Control Office

PHONE: (805) 681-5280
FAX: (805) 681-4069

(Obtain additional forms from your local health department.)

DEPARTMENT OF MOTOR VEHICLES (DMV)

California Driver License or Identification Card Number (eight characters): ☐☐☐☐☐☐☐☐

1. If this report is based upon episodic lapses of consciousness, when was the most recent episode? _____ (mm/dd/yyyy)
2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.
   (a): _____ (mm/dd/yyyy) (b): _____ (mm/dd/yyyy) (c): _____ (mm/dd/yyyy) (d): _____ (mm/dd/yyyy) (e): _____ (mm/dd/yyyy) (f): _____ (mm/dd/yyyy)
3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving? ☐ Yes ☐ No ☐ Uncertain
4. Are additional lapses of consciousness likely to occur? ☐ Yes ☐ No ☐ Uncertain
5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake? ☐ Yes ☐ No ☐ Uncertain
6. Has this patient been diagnosed with dementia or Alzheimer's disease? ☐ Yes ☐ No ☐ Uncertain
7. Would you currently advise this patient not to drive because of his/her medical condition? ☐ Yes ☐ No ☐ Uncertain
8. Does this patient's condition represent a permanent driving disability? ☐ Yes ☐ No ☐ Uncertain
9. Would you recommend a driving evaluation by DMV? ☐ Yes ☐ No ☐ Uncertain

Remarks:

CDPH 110c (1/11) (for reporting conditions reportable to DMV) Page 1