ATTACHMENT A

Applicant with Cognitive Disabilities

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. Comments about the applicant stated disability and level of cognitive ability?

_____

_____

_____

5. Does the applicant have any specific behavioral problems?

☐ YES ☐ NO

If YES,_____

_____

_____

_____

6. Does the applicant travel alone at times? If so, where?_____

_____

_____

7. What abilities does the applicant have to follow directions to make a trip?_____

_____

_____

8. What abilities does the applicant have to understand time and follow a schedule to get places on time? _____

_____

_____

9. What abilities does the applicant have to know when he/she is lost?_____

_____

_____

10. What abilities does the applicant have to get help if he/she is lost?_____

_____

_____

11. What ability does the applicant have to cross a street safely?

_____

_____

_____

12. Comments about the applicant stated ability to travel alone._____

_____

_____

13. Comments about skills related to functional abilities to travel: Orientation to person, place and time. _____

_____

14. Comments on applicant judgment and safety skills related to traveling alone. _____

_____

_____

15. Comments on problem solving and insight skills.

_____

_____

_____

16. Comments on short and long-term memory. _____

_____

17. Comments on concentration (focus attention). _____

_____

_____

_____

18. Comments on ability to seek and act on direction. _____

_____

_____

19. Comments on ability to process information.

_____

_____

_____

20. Comments on consistency (the ability to maintain a particular standard or repeat a particular task with minimal variation).

_____

_____

21. Comments on ability to communicate needs. _____

_____

_____

22. Comments on behavioral skills.

_____

_____

_____

23. Comments about the applicants related physical skills that may affect travel (i.e. walking stability-gait, balance; physical stamina-endurance, or seizures.) _____

_____

_____

PLACE LICENSE PHYSICIAN OFFICIAL STAMP BELOW:

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No.: _____

Business Address: _____

Mailing Address: _____

Telephone No.: _____ Fax: _____