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's stated ability and level of cognitive ability?

   _____

   _____

5. Does the applicant have specific behavioral problems?

   ❑ Yes ❑ No

   If yes, please explain: _____

   _____

6. Does the applicant travel alone at times?

   ❑ Yes ❑ No

   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 to places on time?

9. What abilities does the applicant 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 judgement and safety skills related to traveling alone.

15. Comments on problem solving and insight skills.

16. Comments on short-term 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 applicants related physical skills that may affect travel (i.e. walking stability - gait, balance; physical stamina-endurance, or seizures)

_____

_____

PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW

Signature: _____ Date: _____

Ethnic Origin:

Print Name & Title: _____

Current Guam Medical License No. _____

Business Address: _____

_____

Mailing Address: _____

_____

Telephone No: _____ Fax No. _____