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Directive 2006/126/EC on driving licences
Driving Licence Act 386/2011
Road Traffic Act 729/2018
Regulation TRAFICOM/529906/03.04.03.00/2019

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Fitness to drive - Guidelines for healthcare professionals

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1 Introduction

The Finnish Transport and Communications Agency (Traficom) issues driving licences, driving licence permits, taxi driving licences, driving instruction permits, motorcycle training licences, and driving instructor's licences and parking cards for people with disabilities, renews driving licences, taxi driving licences and driving instruction permits as well as endorses international driving licences. Traficom can also cancel a driving licence permit. Traficom publishes and maintains guidelines and forms concerning fitness to drive.

Ajovarma is Traficom's partner and service provider. Among other things, Ajovarma service points accept driving licence and other road traffic personnel licence applications and their accompanying documents and arranges driving examinations.

The police are responsible for supervising individual drivers' ability and medical fitness to drive. If necessary, the police can ban a person from driving until further notice or on a temporary basis.

Fitness to drive refers to the driver's functional ability in traffic. Its key components include eyesight, cognition and motor function. Many illnesses may have an effect on fitness to drive. The purpose of assessing a driver's fitness to drive is to ensure that the driver's functional ability in traffic remains at a safe level.

It is the task of healthcare professionals to assess whether medical requirements are met. This work is carried out not only by physicians but also nurses and public health nurses who increasingly run their clinics independently and are in charge of routine monitoring of many chronic illnesses, as well as such professional groups as neuropsychologists and occupational therapists, who participate in assessing a driver's cognition and functional ability. This updated guide on fitness to drive is thus targeted more broadly at the entire healthcare personnel.

When dealing with patients, healthcare professionals should, where necessary, assess if the patient is fit to drive a motor vehicle in traffic while they have an illness or disability or are undergoing any investigations, additional tests and treatments. This is always important, not only in terms of an individual patient's fitness to drive and functional ability but also for general traffic safety. In the actual health examinations for determining fitness to drive, the physician must assess if the individual fulfils Group 1 or 2 health requirements with or without restrictions. The results of the examination are conveyed in statements or reports on fitness to drive. According to law, physicians have a duty to notify the police about serious deficiencies in driver health requirements. Nurses and public health nurses also have the right to notify the police if, in the course of their work with patients, they notice that a driving licence holder continuously uses intoxicants.

The purpose of this guideline is to support healthcare professionals in assessing a driver's fitness to drive in different situations. The guideline is based on legislation on fitness to drive, and it was drawn up by Traficom together with experts of clinical specialities. However, this document is not a diagnostic guideline or a handbook intended for specialities. Most driver health assessments are indeed carried out in primary health care and occupational health care services. The guideline sets out criteria for the clinical assessment of fitness to drive in healthcare services and provides grounds for discussing issues related to fitness to drive with the individual and, if necessary, also justifications for a potential driving ban.

By actively and proactively seeking to monitor drivers' health issues and prevent health risks, each healthcare professional can help maintain drivers' ability to drive and general traffic safety.

2 Legislation, regulations and guidelines

2.1 Legislation and regulations

The driver health requirements for road traffic are based on the following directives and acts:

- Directive 2006/126/EC on driving licences
- Driving Licence Act 386/2011
- Road Traffic Act (729/2018).

Under the EU Directive on driving licences, the standards set by Member States may be stricter than those set out in the Directive. Pursuant to the Driving Licence Act, Traficom may issue further provisions on fulfilling the medical standards of fitness to drive.

Traficom's competence to issue provisions is based on the Driving Licence Act (sections 17 and 18):

"The Finnish Transport and Communications Agency may issue further provisions - - - on the fulfilment of medical standards. The Finnish Transport and Communications Agency may issue further provisions on examinations to determine the fulfilment of the medical standards and examinations to assess fitness to drive as well as the content of such examinations, ensuring that the requirements of the Directive on driving licences and traffic safety are met."

In connection with these instructions, Traficom has issued a brief regulation on meeting the driver health requirements (Regulation TRAFICOM/529906/03.04.03.00/2019).

2.2 Driving licence categories

Group 1 driving licence categories include the drivers of motorcycles, passenger cars (total weight less than 3.5 tons), vans (total weight less than 3.5 tons), ambulances (total weight less than 3.5 tons), vehicle combinations pulled by a car as well as tractors and mopeds. Drivers born before 1985 do not need a driving licence to drive a two- or three-wheel moped. A driving licence is always required for driving a light quadricycle. The Group 1 driving licence categories are AM/120, AM/121, A1, A2, A, B, BE, T.

Group 2 driving licence categories include the drivers of lorries, buses and coaches as well as vehicle combinations pulled by these vehicles (total mass over 3.5 tons), i.e. categories C, CE, C1, C1E, D, DE, D1, D1E. Taxi drivers and driving instructors must also always meet the medical standards of Group 2, regardless of the type of driving licences they hold or the weight of the vehicle.

NB! The drivers of ambulances and other emergency vehicles as well as cars or caravans in private use are only required by law to meet the medical standards of

Group 2 if the total weight of the vehicle exceeds 3.5 tons. However, many hospital districts and rescue services have made a local decision to require that all ambulance drivers, among others, meet Group 2 medical standards.

Work machines

A driving licence is not required to drive work machines that are only used off-road in an enclosed area (earthmoving machines, cranes, forklifts, etc.), and the health requirements for driving these machines are not governed by the Driving Licence Act. If necessary, the health requirements for operating the machines must be primarily considered as occupational health issues in cooperation with occupational health care and the employer.

2.3 Guidelines on assessing fitness to drive

These guidelines on assessing fitness to drive are intended as a practical tool for physicians and other healthcare professionals carrying out assessments of fitness to drive. Binding requirements on fitness to drive are laid down in the Directive on driving licences and the Driving Licence Act. The guidelines in themselves are not binding; instead, they contain national interpretations of the legislation mentioned above, instructions applicable to specific illnesses for assessing fitness to drive, as well as operating instructions and examples for different kinds of situations.

However, it is impossible to give detailed or binding guidelines for all situations, and sometimes there is room for interpretation and discretion by healthcare professionals in individual cases. Careful assessment is needed particularly when a patient has several illnesses or disabilities, none of which would necessitate a driving ban alone but which, regarded as a whole, may pose a risk in traffic. In such cases, the conclusions cannot be exclusively based on individual tests or specialist opinions, and a specific physician or healthcare unit must assume the responsibility for making an overall assessment. In demanding assessments of fitness to drive, physicians with special expertise in traffic medicine and multiprofessional care teams or centres providing specialist medical care (e.g. clinics assessing fitness to drive) can also be consulted.

In case of professional drivers, we recommend that the overall assessment of their fitness to drive be carried out in occupational health care services or on the basis of some other long-term care relationship and that the person issuing the opinion has expertise in traffic medicine.

3 Examinations and reports on fitness to drive

3.1 Forms for assessing fitness to drive

The forms can be downloaded from the website suomi.fi: <https://www.suomi.fi>. They are also available at:

<https://www.traficom.fi/en/transport/road/healthcare-professionals>

Forms for assessing fitness to drive (only available in Finnish and Swedish):

- Lääkärintausunto ajokyvystä (Medical report on fitness to drive, F122 / F122r)
Läkarutlåtande om körförmågan (F122)
- Erikoisalan lääkärinlausunto (Specialist medical report, F127 / F127r)
Läkarutlåtande som hör till ett medicinskt specialområde (F127)
- Esitiedot ajokyvyn arviointia varten (Medical history for assessing fitness to drive, F200 / F200r / F200e)
Förhandsuppgifter för bedömning av körförmågan (F200)
- Laajennettu lääkärinlausunto iäkkään henkilön ajoterveydestä (Detailed medical report on an older person's fitness to drive, F201 / F201r)
Utvidgat läkarutlåtande om en äldre persons körhälsa (F201)
- Ilmoitus ajoterveydentilan muutoksesta poliisille (A notification to the police on change in fitness to drive, F203 / F203r)
Anmälan till polisen om förändring i förarens hälsotillstånd (F203)
- Lääkärintausunto liikkumisesteisen pysäköintitunnusta varten (Medical report for a parking card for people with disabilities, F123 / F123r)
Läkarutlåtande för parkeringstillstånd för person med funktionsnedsättning (F123)
- Poliisin määräämä silmälääkärin tai optikon lausunto näkökyvystä (Ophthalmologist's or optician's report on vision requested by the police, F202 / F202r)
Ögonläkares eller optikers utlåtande om synförmågan på polisens uppmaning (F202)

3.2 Personal declaration

Under the current legislation, the applicant can sign a personal declaration in which they confirm that they meet the medical standards of fitness to drive when applying for a first **Group 1** driving licence permit. If the standards are met, a medical report is not needed. If the standards are not met, this declaration cannot be given, and the applicant must submit a medical report on fitness to drive. A previous foreign driving licence also prevents giving a personal declaration.

In **Group 2**, a personal declaration cannot be accepted, and a medical report is always required.

In the **personal declaration**, the applicant affirms that they do not have any of the impairments, illnesses or disabilities described on the back of the driving licence permit application form:

- Progressive eye disease or visual impairment (despite wearing glasses/contact lenses)
- Diabetes mellitus
- Cardiovascular disease (e.g. arrhythmia, myocardial infarction, heart failure or severe hypertension)
- Chest pain or shortness of breath
- Cerebrovascular disorder (e.g. cerebral infarction, cerebral haemorrhage or TIA attack)
- Persistent insomnia, severe tiredness or sleep apnoea
- Mental health disorder (e.g. severe depression, self-destructive behaviour, schizophrenia, psychosis or bipolar affective disorder)
- Personality disorder
- Hyperactivity and attention deficit disorder (ADHD or ADD)
- Mental retardation
- Neurological disease or injury (e.g. epilepsy, narcolepsy, MS, Parkinson's disease, brain tumour, disturbance of consciousness, brain injury or spinal injury)
- Memory disorder
- Recurrent vertigo that limits normal functioning
- Alcohol misuse or dependence
- Drug abuse
- Regular or recurrent use of CNS agents (labelled with a warning triangle)
- Musculoskeletal disease or injury that may hamper the use of the vehicle's controls
- Other serious disease (e.g. a severe pulmonary disease, severe hepatic or renal insufficiency, cancer or organ transplant).

The applicant also affirms that their eyesight has been appropriately checked in the last year and found to fulfil the minimum binocular vision requirement of at least 0.5. The applicant's eyesight can be examined by a physician, a public health nurse or an optician. The visual acuity requirement can also be fulfilled by wearing glasses or contact lenses. In these cases, the applicant should note on the application form that they wear glasses or contact lenses while driving. The special condition of having to wear glasses or contact lenses (01) will then be shown on the driving licence.

3.3 Medical examinations and reports for assessing fitness to drive

As a rule, a medical examination to assess fitness to drive is required in the following situations:

- submitting an application for the first driving licence (excluding Group 1, if giving a personal declaration is possible)
- the driving licence category is to be upgraded from Group 1 to Group 2
- a driving licence is to be renewed after the holder turns 70 (Group 1), or after the holder turns 45 (Group 2).

The police can also order the driver to submit a medical report on their fitness to drive for other reasons.

On medical reports

The results of the examination for assessing fitness to drive are stated in the medical report. The report must always state whether the requirements for fitness to drive have been met. The physician must also always sign the report either in person or electronically. The signature must be accompanied at least with the name in block letters and the physician's identifier. The physician's contact information is also needed in order to obtain further information, if necessary. A medical report cannot be signed on behalf of another person. Further information on drawing up medical reports is available at <https://www.valvira.fi/terveydenhuolto/hyva-ammatinharjoittaminen/laakarinlausunto> (in Finnish and Swedish), among other sources.)

3.3.1 Ordinary examination

A **Group 1** medical examination is carried out in the following situations:

- The applicant is unable to give a personal declaration of meeting the medical standards of fitness to drive when applying for a Group 1 driving licence for the first time (a medical report less than 6 months old required).
- The driving licence has expired.

Licence holders who are about to turn 70 need not provide a medical report to renew their driving licence if the application is submitted at the latest on the applicant's 70th birthday. If renewal is applied for later than this day, an extended medical examination must be carried out.

A **Group 2** medical examination is carried out in the following situations:

- when applying for a first Group 2 driving licence (a medical report less than 6 months old required)
- the driving licence has expired
- when renewing a fixed-term Group 2 driving licence (a medical report is required when the holder turns 45 and subsequently every 5 years)
- to retain a Group 2 right to drive issued before 2013.

Group 2 driving licences issued before 2013 may remain valid until the holder turns 70. In order to preserve their right to drive, however, the driver must submit a medical report to the police within two months of their 50th, 55th, 60th or 65th birthday.

Fitness to drive data and Kanta patient records

On certain conditions, applicants can also apply for a first driving licence, renew an expired/expiring driving licence or upgrade to a Group 2 licence in Traficom's e-services. Applicants can attach to the application their health data directly from the Patient Data Repository if the form *Medical report on fitness to drive (F122)* has been saved to the Kanta database in a digital and structured format. (For more information about this service and the conditions of using it, visit www.ajokortti-info.fi . www.kanta.fi/terveystodistusten-valityys)

3.3.2 Extended medical examination of an older person

Older drivers applying for a driving licence permit or renewing their driving licences are required to submit their applications accompanied by a medical report of meeting

the medical standards of fitness to drive. The police can also issue a specific order requiring a person to submit a detailed medical report.

Group 1

A detailed medical report is required if the applicant is submitting a driving licence permit application to renew their right to drive after having turned 70, in other words the day following their 70th birthday or later.

If the applicant has not yet turned 70 when submitting their application for a driving licence permit, no medical report is required.

Once a driver has turned 70, a group 1 driving licence must be renewed every five years, and a detailed medical report is always required at every renewal.

Group 2

A detailed medical report is required:

- if the applicant has turned 68 before the medical examination is carried out
- if the applicant turns 68 before the driving licence to be renewed expires.

Once the holder has turned 68, the driving licence is always renewed for two years at a time, and an extended medical examination is always required.

In Group 2, the first extended medical examination is thus usually carried out when the licence holder is aged between 68 and 70, and subsequently every two years.

Medical history forms (F200 and F201)

At home before coming to an extended medical examination, the applicant fills in the medical history form that has been sent to the applicant (*Medical history for assessing fitness to drive, form F200*), which will be filed with the patient records. During the appointment, the applicant also fills in the first page of the form *Detailed medical report on an older person's fitness to drive (F201)* under the supervision of a nurse or a physician (this form is not sent to the licence holder prior to the appointment).

The physician fills in the second page of this form as part of the extended medical examination. The first section of this page is crucial: if the physician is not already familiar with the applicant's state of health, sufficient information on it must be obtained. To support their personal assessment in the examination, the physician may have the patient complete tests intended for assessing cognitive performance, disorders of intellectual functional ability or the degree of dementia. The test carried out and its results should be recorded on the form. The form *Detailed medical report on an older person's fitness to drive (F201)* should be filed with the patient records.

During the extended medical examination, the physician completes the form *Medical report on fitness to drive (F122)* or uses the corresponding electronic report. The conclusions regarding the fulfilment of medical standards are recorded in the report. Page 3 of the form (*Copy for the authorities*) should be

- handed to the licence holder, who will submit it to Ajovarva, or
- sent directly to the police if a medical report on fitness to drive has been requested by the police.

The electronic report is stored in structured format in the Patient Data Repository or, if necessary, printed out for the person to be delivered further.

The indication 'Extended medical examination' should be entered on the form as the purpose of issuing the form, and the conclusions should contain the fact that they are based on an extended examination.

3.3.3 Specialist medical examination

When assessing an individual's fitness to drive, a physician may request additional tests and consult a specialist if necessary. After receiving the required additional information, physicians record their final conclusions on the form *Medical report on fitness to drive (F122)*.

Sometimes, however, fitness to drive is assessed from the perspective of a single speciality. The driver may have a chronic condition (e.g. diabetes, cerebrovascular disorder, dementia or glaucoma) that may require regular monitoring by specialised medical services and a specialist assessment of their fitness to drive after a set period. In these situations, the form *Specialist medical report (F127)* is used. The form is always submitted to the police by the relevant specialist.

NB! If a chronic illness is monitored in primary healthcare services or occupational health care on medical grounds, a periodical report on fitness to drive can usually be issued by the treating physician, in consultation with specialised medical care if necessary.

The specialist medical report form is used when

- the driver was ordered at a previous medical examination for assessing fitness to drive to have a medical check-up by a specialist earlier than usual,
- the police has ordered the driver to submit a specialist medical report,
- the purpose of the examination is to add or remove special conditions on the driving licence (glasses, hearing aid, alcohol interlock device).

First driving licence and a specialist assessment:

A young person applying for their first driving licence may also have a chronic illness that requires treatment or monitoring by a certain medical speciality. A *Specialist medical report (F127)* is not sufficient for applying for a driving licence permit; instead, an overall assessment of fitness to drive and a *medical report on fitness to drive on form F122* are always required. For example, the treating specialist may write a freely worded statement on the status of the illness being treated, which is handed to the patient for the medical examination for assessing fitness to drive. However, the medical examination is usually conducted and the medical report on fitness to drive is issued in primary health care (e.g. pupil or student health care services).

In certain rare situations, the police may order a driver to undergo an assessment by an ophthalmologist or an optician specifically to have their eyesight examined. In this case, the form *Ophthalmologist's or optician's report on vision requested by the police* is used (F202).

3.3.4 Conclusions and limitations of reports

The authority makes a decision on the fitness to drive of the person being examined based on the medical reports on fitness to drive. The conclusions of the reports must

always include a clear statement of the fitness to drive of the person being examined.

If the conclusions include a condition of wearing glasses for Group 2 driving licences, the need for glasses concerning Group 1 must also be always assessed and determined.

An alcohol interlock device is never specific to a vehicle or type of driving licence. If an alcohol interlock device has been set as a condition for meeting the requirements on fitness to drive, it applies to all types of driving licences and must be set as a condition for both Group 1 and Group 2.

3.4 Procedure for issuing reports on fitness to drive

Medical reports related to driving licence applications are received by Ajovarma, a company providing services for Traficom. Reports related to fitness to drive and its supervision are received and processed by the police. **The reports are never sent to Traficom.**

The reports related to applications are handed to the applicant to be submitted to Ajovarma. They can also be sent directly to the police by the health care services. Electronic reports are stored in structured format in the Patient Data Repository or, if necessary, printed out for the person to be delivered further. By law, however, the individual in question is always personally obligated to submit the report to the authority in time for the processing of the driving licence or other permit issue. The page of paper reports titled *For the patient* is always handed to the applicant.

3.4.1 Report handed to the patient

Medical report on fitness to drive (F122)

- a medical report for applying for or renewing a driving licence
- a medical report for a taxi driving licence or a driving instructor's licence
- a report based on an extended medical examination for assessing fitness to drive.

The applicant submits the page titled *For the authorities* to the Ajovarma service point of their choice as an attachment to their driving licence application.

At the same time, the physician can fill in report *F122 (Medical report on fitness to drive)*, ordering the driver to use glasses, a hearing aid (Group 2) or an alcohol interlock device. Any other special conditions should only be entered on the basis of a driving test or demonstration of driving skills.

NB! If, in the examinations referred to above, it is found that the holder of a driving licence or driving licence permit does not meet the medical requirements and will be unfit to drive for at least six months, the physician should also fill in the form *Notification to the police on change in fitness to drive (F203)* and send it directly to the police department in the patient's place of residence.

3.4.2 Report submitted directly to the police

Medical report on fitness to drive (F122) when the examination has been carried out:

- based on a certain age (Group 2 drivers whose driving licence is valid until they turn 70)

- based on a medical examination that has been brought forward
- to make a decision on a driving ban on health grounds
- by order of the police.

A *specialist medical report (F127)* is always submitted to the police.

Notification to the police on change in fitness to drive (F203)

If, in the examinations referred to above, it is found that the holder of a driving licence or driving licence permit does not meet the medical requirements and will be unfit to drive for at least six months, the physician should also fill in the form *Notification to the police on change in fitness to drive (F203)* and send it directly to the police department in the patient's place of residence.

3.4.3 Other forms

The forms *Preliminary information for assessing fitness to drive (F200)* and *Detailed medical report on an older person's fitness to drive (F201)* are intended for preliminary data and should not be sent anywhere; they are kept in the patient records at the healthcare unit.

The form *Medical report for a parking card for people with disabilities (F123)* is handed to the applicant, who submits it to an Ajovarma service point as an attachment to the paper application or via Traficom's e-services as an attachment to an electronic application.

3.5 Driving bans and notifications

3.5.1 Temporary impairment of fitness to drive (less than 6 months) and a short-term driving ban imposed by a physician

In many cases, a person's fitness to drive may be impaired on a temporary basis, without a need to contact a physician or other healthcare services. Such cases include tiredness, sudden infectious diseases or other unusual symptoms. Under section 17 of the Road Traffic Act, the driver has a personal responsibility not to drive when unfit to do so. Drivers who use medicines marked with a red warning triangle must also assess their own fitness to drive a vehicle. The healthcare personnel have a duty to inform a driver of any side effects of medication or symptoms of an illness that may impair his or her fitness to drive.

When a physician finds that a driver is unfit to drive on a temporary basis, they will discuss the situation with the patient and tell him or her that driving is not permitted, explaining the reasons for this ban. The ban is recorded in the patient history, a printout of which is handed to the patient. Temporary driving bans are not notified to the police. It should be explained to the patient that in case of an accident, violating this ban may mean a reduced insurance pay-out or criminal liability. While it is usually not possible in emergency care situations to focus on issues concerning fitness to drive over the long term, the emergency care unit should already impose a temporary driving ban if necessary.

3.5.2 Long-term impairment in fitness to drive (at minimum 6 months) and the physician's duty to notify the police

Under section 21 of the Driving Licence Act, the physician is, notwithstanding the duty of confidentiality, under an obligation to notify the police if the health of a driving licence holder or applicant no longer meets the medical standards of fitness to drive laid down in section 17 or 18 because of continuous use of intoxicants or

because his or her health has deteriorated for some other reason and this deterioration is not temporary. The physician must always notify the police when the unfitness to drive is expected to last for more than six months. In this case, the physician completes the form *Notification to the police on change in fitness to drive (F203)* and sends it directly to the police in the patient's place of residence. The patient should be informed of the driving ban and the fact that this form will be sent to the police, before notifying, but his or her consent is not required. The justifications for the driving ban should be carefully recorded in the patient history and explained to the patient.

If the patient's health improves and he or she meets the medical requirements again, the physician should complete the *Medical report on fitness to drive (F122)*. This form is submitted to the police either by the patient or the physician. The police can reinstate the person's right to drive on the basis of this report.

NB! Regardless of the illness or other reason resulting in a driving ban, the physician has a duty to submit the notification to the police when the statutory criteria are met. This is vital for ensuring the safety of all road users.

Preconditions for notifying the police

Under the Driving Licence Act, a notification must be submitted if the physician *finds* that the medical standards of fitness to drive are not met. As a point of departure, the physician should personally examine, diagnose and document the driver's state of health. It is thus not recommended to base a notification exclusively on second-hand information, for instance, or individual patient documents without meeting the person. Exceptions to this include, for instance, multidisciplinary centres for the assessment of fitness to drive, when there is comprehensive information available on the fitness to drive of the person being examined and the risk to traffic safety is clear.

3.5.3 A nurse's and public health nurse's right to notify the police of a driver's continuous use of intoxicants

Under section 21 of the Driving Licence Act, notwithstanding the provisions on duty of confidentiality, nurses and a public health nurses have the right to inform the police if an applicant of a driving licence permit or a holder of a right to drive no longer meets the health requirements laid down in section 17 or 18 due to continuous intoxicant use. The notification right only applies to patients encountered by nurses in their professional capacity and exclusively intoxicant use, not other health data. The notification is given with the form *Notification to the police on change in fitness to drive (F203)*. It is submitted directly to the police in the patient's place of residence.

Intoxicant abusers generally visit emergency health care services frequently and, in this context, meet a nurse if their illness does not require treatment by a physician. A nurse is entitled to make a notification when they become aware of a patient's intoxicant abuse problem, for example in connection with repeated emergency care visits. The criteria may also be met when a patient is encountered in occupational health care and health monitoring, or in connection with other repeated meetings. Nurses also often have the possibility of consulting a physician in their work to support them in patient situations that are difficult to assess. The patient's consent is not required to make a notification, but under the Act, before notifying, the patient must be informed of the notification being submitted and the nurse's right to submit it. These notifications are necessary in order to ensure the safety of all road users.

Dissatisfaction with a driving ban

If a patient is dissatisfied with a *temporary driving ban* imposed by a physician, they can *complain* about the physician's actions to the responsible director of the healthcare unit, or (secondarily) to the State Regional Administrative Office (AVI).

If a patient is dissatisfied with a *driving ban imposed by order of the police*, they can submit a request for a *revised decision* to the authority that made the decision.

3.6 Driving test, demonstration of driving skills and voluntary test of fitness to drive

The medical report must always include a statement on whether the person meets the medical standards of fitness to drive. If the physician finds that a driver meets the medical standards of fitness to drive but wishes to ascertain that he or she is capable of driving in traffic or using the vehicle's assistive control devices, the physician states in the conclusions that the standards of fitness to drive are met and recommends a driving test or a demonstration of driving skills. The driving test and demonstration of driving skills are based on the Driving Licence Act.

If, on the other hand, the physician is not fully certain of whether or not a driver is fit to drive safely, they may require him or her to undergo a voluntary test of fitness to drive and use the feedback on the test to support their conclusions.

3.6.1 Driving test

In a driving test, the examiner (Ajovarma) assesses the driver's command of the rules of the road and the vehicle in a normal traffic flow. The driving test contents are always standardised, and the driver is not required to take a theory test. Rather than drawing up a separate referral to the driving test, the indication "Driving test" is noted in the "Additional requirements" section of the report on fitness to drive (*F122 or F127*). In case the applicant is applying for or renewing their driving licence or applying for a taxi driving licence (see section 3.2.1), the applicant will personally contact an Ajovarma service point of their choice. On the other hand, in situations where the report is submitted directly to the police (see section 3.2.2), the police orders the client to take a driving test, after which the client can themselves contact an Ajovarma service point of their choice.

When a person is applying for their first right to drive, a separate driving test cannot be required as one is already included in their examination. If the person's mobility is reduced, the examiner also assesses the need for assistive control devices, if any, during the driving test.

The physician will only receive feedback on the results of the driving test by separate agreement with the patient. The right to drive is automatically reinstated if the patient passes the driving test.

3.6.2 Demonstration of driving skills

The purpose of the demonstration of driving skills is to examine on a case-by-case basis a driver's ability to use the controls of the vehicle, either as such or equipped with the assistive control devices that he or she may need. If automatic transmission is required, this is also regarded as an assistive control device, and a demonstration of driving skills must be completed. The demonstration of driving skills is not suitable for assessing the driver's ability to observe traffic.

By a physician's suggestion, the police may order a person to give a demonstration of driving skills. Therefore, only a driver with a valid right to drive may be ordered to give a demonstration. In other words, the demonstration of driving skills is not suitable for situations where a person is applying for their first driving licence or if their right to drive is not valid for some other reason. The physician indicates the need for a demonstration of driving skills on the report on the fitness to drive (*F122 or F127*) by ticking the relevant box, after which the police will order the person in question to give a demonstration. The examiner (Ajovarma) produces for the police a report on the demonstration of driving skills to support the police in making a decision on the right to drive or imposing any special conditions. The demonstration is given at an Ajovarma service point.

The physician will only receive feedback on the results of the demonstration by separate agreement with the patient. The right to drive is automatically reinstated if the patient passes the demonstration, and conditions concerning assistive control devices are added to the driving licence, if necessary.

3.6.3 Voluntary test of fitness to drive

As part of their assessment of fitness to drive, a physician may, to support their decision before making any conclusions, send a person to a driving school or other organisation specialising in assessments of fitness to drive for a so-called voluntary test of fitness to drive. A voluntary test of fitness to drive is not recorded on the form on fitness to drive. The test is not based on the Driving Licence Act, and it is a voluntary additional tool for assessing fitness to drive. It does not replace a driving test, and additional conditions for the right to drive cannot be specified exclusively on the basis of a voluntary test.

The test is taken in normal traffic, usually in a driving school car and under the supervision of a driving instructor. A physician or some other healthcare professional may participate in the test. The test has no specific format and it is individual; therefore, it is important that the physician provide the driving instructor with sufficient preliminary information on aspects of driving that should be focused on. This background information can be set out in the patient history or a separate document that the driver gives to the driving instructor. The physician will use the driving instructor's report on the test to support their medical opinion on whether the person meets the medical standards of fitness to drive (*Medical report on fitness to drive, form F122*).

NB! If the medical examination for assessing fitness to drive already has clearly shown that the relevant health requirements are not met, this fact cannot be changed by a driving test, a demonstration of driving skills or a voluntary driving test.

3.7 Disqualification of physicians

When drawing up medical reports on fitness to drive, physicians exercise their statutory right to carry out assessments. As this concerns an important interest of the applicant, the physician has the duty to consider whether he or she should be disqualified from drawing up reports.

A physician may be disqualified from issuing a medical report on fitness to drive if the following grounds compromise his or her impartiality:

- the person in question is close to the physician
- the physician or persons close to him or her can expect a particular benefit or incur losses as a result of the decision
- confidence in the physician's impartiality is undermined for some other particular reason.

Under the Administrative Procedure Act, a person close to a physician means:

- the physician's spouse, child, grandchild, sibling, parent or grandparent, or a person who is otherwise particularly close to the physician, or the spouse of any of these persons
- a sibling of the physician's parent or the spouse of such a sibling, a child of the physician's sibling, or the physician's former spouse
- a child, grandchild, sibling, parent or grandparent of the physician's spouse, the spouse of such a person, or a child of a sibling of the physician's spouse.

A corresponding step-relative is also considered a close person. The term 'spouse' refers to a marriage partner or a person living in marriage-like circumstances or in a registered partnership with the person concerned.

Further information on a physician's disqualification (in Finnish and Swedish):

<https://www.valvira.fi/terveydenhuolto/hyva-ammatinharjoittaminen/laakarinlausunto>

4 Assessment of fitness to drive

Fitness to drive should be assessed at all visits to a physician, not only when a driver comes in for a medical report for a driving licence. When a driver's functional ability is assessed for such purposes as a sickness allowance, a disability benefit or a parking card for people with disabilities, their impaired functional ability may also affect their fitness to drive.

The medical report must always include a statement on whether the standards of fitness to drive are met. In the assessment of fitness to drive, attention should be paid to obtaining sufficient information on the patient's state of health and functional ability – including on any traffic violations and accidents if necessary. It is impossible to express an opinion on fitness to drive without sufficient information about the person's eyesight, cognition and motor functions while driving, and an effort should thus be made to examine the patient's functional ability as extensively as possible before issuing a report. In this assessment, physicians should also rely on other healthcare professionals if necessary (e.g. nurses and public health nurses, neuropsychologists and occupational therapists). The information in the Kanta service (Patient Data Repository) on the patient's history, medication and previous examinations of fitness to drive should be actively used in the assessment.

The goal is that the assessment of and the report on fitness to drive would first and foremost be drawn up in primary or occupational healthcare services or based on some other long-term patient relationship. Professional drivers should primarily be assessed in occupational healthcare if they are covered by these services. Especially

when assessing the fitness to drive of an older patient with multiple illnesses, it is important that the assessment is made by a physician who is well familiar with the patient's state of health. When a patient has regular medical check-ups due to a chronic illness, the assessment of fitness to drive can be produced in connection with one of these visits.

NB! The fulfilment of the medical standards of fitness to drive may only be assessed on medical and traffic safety grounds, and the person's mobility needs, income or driving conditions cannot be taken into consideration. A restricted right to drive is not used in Finland, and special permits concerning health requirements are not granted.

4.1 Cognitive fitness to drive

Key areas of cognition in driving are cognitive control, visual perception and regulation of alertness. Operating a vehicle is based on these functions, which are underpinned by operating models honed with driving practice. Driving requires an ability to make and process observations. In many situations critical for road safety, the driver must make complex choices and rapid decisions on actions based on these observations. Many factors may impair one or several functions temporarily or permanently, resulting in inadequate use of the operating models for driving in traffic. Sufficient alertness and a stable level of consciousness are basic preconditions for the cognitive functions required for driving.

Key cognitive functions for driving

Cognitive control means judicious, goal-oriented and appropriate action in traffic.

Visual perception refers to interpreting and understanding visual information obtained through the eyes.

Concentration, i.e. regulation of alertness, in traffic means an ability to focus on aspects that are essential for driving and road safety.

Above all, cognitive control includes the planning of the journey and driving route before starting to drive, taking into account the driving conditions and the driver's personal functional ability. While driving, cognitive control means that the driver can anticipate situations as well as observe and correct his or her errors. In changing driving conditions and unusual traffic situations, drivers also need the ability to flexibly change their driving plan. Additionally, cognitive control includes the driver's ability to regulate emotional reactions and control his or her behaviour, keeping traffic safety in mind both when planning the journey and actually driving.

Important aspects of visual observation are scanning the traffic view to anticipate changes, perception of the surrounding space that allows the driver to understand distances, as well as perceiving other road users' directions of travel in relation to the driver's own direction. Well-functioning driving vision is a basic precondition for making observations on the road, but examinations of the different areas of driving vision and assessment of visual perception are not mutually interchangeable.

Concentration means that driving is not disrupted by inessential elements of the multitude of environmental stimuli or the driver's bodily feelings and emotional states. Of the different areas of alertness, the correct direction of visual and auditory perception and maintaining alertness play a key role in traffic. In complex traffic situations, drivers must also be prepared to respond to unexpected changes in their

field of observation and be able to flexibly refocus their alertness. The speed and flexibility of decisions made in traffic situations are included in the regulation of alertness. Effective motor functions in the limbs used to operate the vehicle's controls are a basic precondition for putting decisions into practice – but the motor functional ability itself can be supported with technical solutions.

A physician's opinion on the cognitive preconditions for driving is vital in the sequelae of neurological illnesses, in connection with psychiatric and neuropsychiatric disorders, as well as for patients with multiple illnesses and multi-medication that affects brain functions. A physician's opinion is also required when an applicant is suspected or known to have an impairment or restrictions in key cognitive functions, which may prevent him or her from gaining sufficient experience of the relevant operating models. Knowledge of cognitive functional ability is often also needed in connection with changes in driving vision or special motor problems.

4.1.1 Factors affecting cognitive capabilities

Many illnesses and medicines affect alertness and coping. A major drop in alertness and severe fatigue can easily lead to falling asleep at the wheel. It is important for all drivers to monitor their level of alertness, know when they are feeling tired, and understand what this means for safe driving. Regulation of alertness and cognitive control are impaired when the driver is tired, even if the operating models of driving do not change as such; the driver's attention is narrowed, decision-making is slower and indifference towards problems in the driving performance tends to increase.

In the sequelae of cerebral illnesses, it is usual for even well-practised cognitive operating models to become less automatic. Driving requires additional effort and oversight provided through cognitive control, which increases the strain and makes the driver even more susceptible to tiredness.

Personal assessment of functional ability is important in the context of all illnesses and disabilities, and under the Road Traffic Act, the driver is responsible for making such assessments. Drivers should recognise impairments in their functional ability associated with illnesses or medication and, similarly, understand the significance of increased susceptibility to tiredness, changes in their level of alertness and the risks inherent in their driving style. When drivers understand the changes in their own functional ability they are more likely to have a positive attitude towards treatment, to accept and comply with the treatment instructions they receive (e.g. monitoring their blood sugar levels).

In injuries and illnesses affecting brain functions, a driver's ability to recognise and accept changes in his or her functional ability may be reduced because he or she does not feel ill, or is not aware of the symptoms. This is about cerebral inability to observe and understand changes in one's functional ability, which is always a risk to traffic safety.

To investigate suspected unawareness of symptoms or lack of judgement, information on a patient's health and medication as well as his or her practical functional ability is always needed. In this respect, interviewing persons close to the patient or those who know him or her well is in key role. It is important to have information on the patient's level of consciousness and any changes in his or her judgement required for driving or for managing responsibly and independently, and changes in his or her characteristic behavioural control and judgement in relation to the requirements of social situations.

4.2 Ageing and fitness to drive

Older drivers have many years of driving experience, and older persons who continue to drive are constantly updating their techniques for coping in traffic. On the other hand, old age increases the risk of many illnesses that affect fitness to drive. A driver's senses, motor functions and cognition are also affected by slowly changes. Mere age-related changes do not impair well-practised perception and operating models of driving. They thus rarely are an obstacle to driving for an older person who has no illnesses that reduce his or her functional ability.

The reasons for road accidents caused or sustained by older drivers mainly include cardiac, cerebral and vascular events and attacks that result in a sudden loss of functional ability or an unexpected abnormality. The most important reasons for errors made by older drivers in traffic are multiple illnesses and multi-medication affecting the central nervous system, which is often also associated with a reduced level of alertness or increased susceptibility to fatigue. Particular challenges include delirious states, even when mild, and the early symptoms of slowly progressing memory disorders, which tend to focus selectively on memory, alertness or cognitive control.

Especially in an extended medical examination, physicians should assess the fulfilment of all medical requirements as well as the person's overall fitness to drive, taking into account all illnesses, impairments and health changes affecting the person's fitness to drive, as well as their combined effects. When assessing older persons' fitness to drive, a driving test or a voluntary test of fitness to drive may be useful where necessary.

4.3 Reduced mobility and assistive control devices

According to the Directive on driving licences, the effects of any illnesses or injuries must be evaluated to assess whether the medical standards of fitness to drive are met. The medical requirements are not fulfilled if the person has a musculoskeletal illness or injury that puts traffic safety at risk and results in impaired functional ability that cannot be compensated for by assistive control devices.

The physician states in the report his or her opinion on the driver's fitness to drive. The report does not include an opinion on assistive control devices; instead, the physician may recommend that the person take a driving test, or give a demonstration of driving skills (in the *Additional requirements* section of the report). The examiner determines the necessary assistive control devices during the driving test or demonstration of driving skills. NB! Demonstration of driving skills is only possible if the person already has the right to drive. In contrast, a separate driving test cannot be arranged for a person applying for their first driving licence, because a driving test is already included in the examination. (See Section 3.6. for more details.) In the future, a physician will assess the person's health and fitness to drive while using these devices and only proposes a demonstration of driving skills if reviewing the situation is necessary.

In compliance with the Directive, due consideration shall be given to the additional risks and dangers involved in the driving of vehicles of Group 2, i.e. heavy vehicles. Concerning driving professionally, requirements on the ability to function related to issues other than the mechanical act of driving itself should also be taken into account, if necessary. For instance, taxi drivers must be able to assist their customers and ensure their safety in all situations. As for drivers operating heavy vehicles, they usually need to handle the cargo in their work and take care of the

inspections and maintenance of the large vehicle in connection with driving, among other things.

5 Assessment of fitness to drive in case of specific illnesses

E00 – E99 Endocrine diseases

E10 – E14 Diabetes mellitus

The fitness to drive of persons with diabetes mellitus should be monitored by means of regular check-ups. It is recommended that the medical examinations of diabetes patients are conducted by a physician at intervals of 1 to 5 years (Group 1) or 1 to 3 years (Group 2). If there has been no change in a person's fitness to drive, this is recorded in the patient data, and no other notifications are usually required.

In terms of traffic safety, particular attention should be paid to hypoglycaemias that occur without prodromes or are severe (requiring assistance from another person) and recurring (at least twice within 12 months). On the other hand, hyperglycaemia also affects concentration and alertness and may thus reduce fitness to drive. Any other illnesses and co-morbidities should be taken into account in the overall assessment of the situation. Retinopathy may affect vision and neuropathy the functional ability of feet. Insulin treatment in particular but also sulphonylureas and glinides increase susceptibility to hypoglycaemia.

Hyperglycaemia

Hyperglycaemia may also affect alertness, among other things. However, these effects are individual, and determining general threshold values (blood sugar level or HbA1c) is difficult. In insulin-treated diabetes, attention should be paid especially to hyperglycaemias that have led to ketoacidosis. Hyperglycaemias, which cause symptoms in all diabetes patients, may mean an increased risk in traffic also in more general terms.

It is essential for fitness to drive that patients can recognise hypoglycaemia and hyperglycaemia symptoms and take action when experiencing them. Patients must also monitor their blood sugar levels regularly and sufficiently from the viewpoint of driving and traffic safety. Blood sugar balance should be assessed by means of objective methods.

Drivers' personal responsibility means that drivers only drive when they are fit to do so. However, physicians should support persons with diabetes in preserving their fitness to drive by means of advice and appropriate treatment.

In **Group 1**, a person with diabetes mellitus meets the medical standards of fitness to drive if:

- Regular monitoring and check-ups are carried out and the patient's fitness to drive is assessed and documented every 1 to 5 years.
- The patient has not had a severe hypoglycaemic event twice in the last 12 months.
- The cause of any isolated severe hypoglycaemias has been investigated, and an effort has been made to prevent its recurrence by means of patient education and modifications of treatment.

- The patient is able to recognise the symptoms of low blood sugar.
- The patient demonstrates an understanding of the risk of hypoglycaemia to driving.
- Those using insulin or other medicines that increase the risk of hypoglycaemia (sulphonylureas, glinides) monitor their blood sugar levels following the treatment plan.
- The traffic safety risks caused by hyperglycaemia have also been taken into account.
- Diabetes is not associated with co-morbidities that essentially impair fitness to drive.

If the patient has had at least two severe hypoglycaemic events in the last 12 months during waking hours, the requirements of fitness to drive are not regarded as being fulfilled for three months following the most recent episode, unless a favourable medical opinion is issued by the physician treating the diabetes, and the diabetes is monitored regularly. A short driving ban (less than 6 months) should be documented in the patient history. Longer driving bans shall also be notified to the police.

In **Group 2**, a person with diabetes mellitus meets the medical standards of fitness to drive if:

- Regular monitoring and medical check-ups are carried out and the patient's fitness to drive is assessed and documented every 1 to 3 years.
- The patient has not had a severe hypoglycaemic event in the last 12 months.
- The patient is fully able to recognise the symptoms of low blood sugar.
- Those taking insulin or other medicines that increase the risk of hypoglycaemia monitor their blood sugar levels at least twice a day and in connection with driving (before starting to drive and every 2 to 3 hours while driving).
- The patient demonstrates an understanding of the risk caused by hypoglycaemia to driving.
- The risks caused by hyperglycaemia have also been taken into account.
- Diabetes is not associated with co-morbidities that essentially impair fitness to drive.

If the patient has had even a single severe hypoglycaemic event, the physician bans them from driving Group 2 vehicles and notifies the police. Co-morbidities of diabetes may also be a cause for a driving ban. Intensified patient education and the requisite changes in treatment are initiated. If severe hypoglycaemia does not recur within a 12-month monitoring period, the driving ban can be lifted, provided that the other criteria are also fulfilled. If the status of the patient's diabetes significantly improves at a later stage, however, the patient can apply for a new Group 2 driving permit, submitting a report from a diabetes specialist.

Professional drivers and diabetes mellitus

Group 2 medical standards of fitness to drive apply to almost all professional drivers, including taxi drivers. HGVs, professional transport of passengers and long driving distances increase their risks compared to other drivers. Professional drivers' fitness to drive should be monitored regularly and frequently enough, primarily by occupational health care services. In the context of diabetes, particular attention should also be paid to the safety risk caused by potential hyperglycaemia.

F00 – F99 Mental and behavioural disorders

F00 – F03 Dementia

See G30 – G32 Alzheimer’s disease and other degenerative diseases of the nervous system.

F10 Harmful alcohol use and alcohol dependence

Alcohol is one of the key risk factors for road safety. In addition to drinking and driving, a driver’s fitness to drive may also be reduced by other reasons, including tiredness caused by a hangover and cognitive disorders resulting from long-term alcohol use. Drinking may also worsen the symptoms of other illnesses (e.g. susceptibility to arrhythmia), with a negative effect on fitness to drive. Excessive alcohol use may also be associated with syncopal episodes. The combined effects of alcohol and many medicinal substances may significantly impair driving performance.

When assessing the impacts of alcohol on fitness to drive, a key target group consists of patients whom a healthcare professional observes engaging in harmful behaviour associated with intoxicant use that puts traffic safety at risk, or such behaviour comes to their knowledge, without the criteria for diagnosing dependence being met. Persons in this group are still expected to be able to change their behaviour and intoxicant use, and before the withdrawal of the driving licence is recommended, there must be evidence of the person being incapable of change, despite guidance or support provided. Harmful behaviour includes repeatedly riding a bicycle while intoxicated or driving a car with a hangover, repeatedly being taken into custody, and recurring visits to emergency care services due to alcohol-related accidents or alcohol poisonings, for example. Withdrawal symptoms requiring treatment or alcohol rehabilitation treatments indicate alcohol dependence.

The medical standards of fitness to drive are not met if the driver cannot refrain from drinking and driving. In more general terms, alcohol dependence is also a reason for withdrawing a driver’s right to drive if treatment and monitoring are not adequate to ensure abstinence (e.g. controlled Antabuse treatment and regular breathalyser tests). Under the Driving Licence Act, the medical standards of fitness to drive can also be regarded as being met if the vehicle used by the driver has an alcohol interlock device that prevents drinking and driving. The condition of using an alcohol interlock device can thus be set on the driving licence. Should the physician be unsure of the criteria for the right to drive being met, he or she may instead suggest that the driver use an alcohol interlock device on health grounds.

Moreover, the police may order a driver to be examined by a specialist in addiction medicine based on their surveillance observations (e.g. driving while intoxicated) or a recommendation given by a physician in an earlier examination for assessing fitness to drive. The form *Specialist medical report (F127)* is used for an assessment ordered by the police. Regional practices are followed in healthcare services to assess intoxicant use.

Example: Assessment of intoxicant use by order of the police

As a rule, the assessment period should not exceed three months. The assessment includes:

- careful collection of preliminary information and an Audit questionnaire
- a clinical examination
- laboratory tests if necessary (B-PEth, S-CDT, S-GT and E-MCV when investigating alcohol use, and drug and medicine screenings from urine when investigating abuse of drugs and medicinal substances)
- if necessary, patient documents should be requested from other healthcare units.

In mild cases, a driving ban imposed by a physician is initially sufficient, followed by three-month monitoring with laboratory tests (e.g. PVK, ALAT, ASAT, GT, CDT/DST and B-PEth) and breathalyser tests. During this period, the physician should meet the person regularly once or twice a month. The emphasis at these meetings should be on raising the driver's awareness of the way intoxicants affect fitness to drive and correcting any dismissive or positive attitudes towards driving while intoxicated. It is also important to support operating models that help achieve permanent changes.

In the most severe cases, giving an unfavourable medical opinion is initially recommended, followed by six-month monitoring with laboratory tests, breathalyser tests and regular meetings. The emphasis at the meetings should be on changing harmful behaviour, arriving at a more detailed diagnosis of the intoxicant abuse problem, and referring the person to treatment if necessary.

After the monitoring period, a favourable medical opinion on reinstating the right to drive for a fixed term of 6 to 12 months at a time should initially be issued (with an indication of an early examination of fitness to drive on the form *Specialist medical report F127*), until it is likely that the person can refrain from driving while intoxicated. An alcohol interlock device on health grounds can be used during and after the monitoring period.

Based on regular medical check-ups and a statement from a specialist in addiction medicine or other physician with expertise in assessing intoxicant use, a driver previously found to be suffering from alcohol dependence may be considered to meet the medical standards of fitness to drive if his or her alcohol use no longer puts traffic safety at risk.

Other physician with expertise in assessing intoxicant use

An assessment of fitness to drive regarding intoxicants can also be carried out by a general practitioner or an occupational health care physician who is familiar with the patient's situation and the basics of assessing intoxicant use. In this case, too, the physician should use the form *F127 Specialist medical report* and, in the section *Specialisation*, tick the option *Addiction medicine*.

The medical standards of fitness to drive are not met if alcohol use has resulted in permanent health changes that have a negative effect on fitness to drive or put road safety at risk, affecting the driver's general functional ability, perception, judgement, reactions or behaviour. Such changes include permanent alcohol-induced organic changes in the central nervous system or balance, impairment of cognitive functions or personality changes. The effects of these permanent changes cannot be counteracted by using an alcohol interlock device on health grounds.

When alcohol dependence or a persistent alcohol-related disorder is diagnosed, a driving ban of at least one month should be imposed, and treatment and monitoring procedures for treating the dependence should be initiated. If treatment response is inadequate and it is necessary to extend the driving ban for more than six months, the police must also be informed. If treatment response is adequate, reinstating the right to drive may be considered.

Chronic alcohol-related disorder that compromises fitness to drive

If a person meets the following probability criteria of the Current Care guideline, this may indicate a persistent alcohol-related disorder that compromises fitness to drive:

- The alcohol content in the patient's blood or exhaled air at a pre-booked appointment exceeds 1 pro mil.
- An alcohol content exceeding 3 pro mil is found in any situation.
- The alcohol content has exceeded 1.5 pro mil with no outward signs of intoxication.

According to the Current Care guideline, the diagnosis of alcohol dependence should not, however, be based on a single (emergency) visit or otherwise insufficient information.

If a **Group 1** driver has had even a single verified seizure associated with alcohol withdrawal, the physician must impose a temporary driving ban for three months. Such symptoms as myoclonus are not regarded as a seizure unless disturbances in consciousness are present. If the seizures do not recur, the driving ban can be lifted.

If a **Group 2** driver has experienced a verified seizure associated with alcohol use, as a rule a minimum period of five years without seizures is required before the right to drive can be reinstated. The policy must also be notified. The same period of five years without seizures is also required when considering a new Group 2 right to drive. In this connection, too, it is important to ascertain that the patient no longer uses intoxicants.

Alcohol withdrawal seizures and driving ban length

A seizure associated with withdrawal from alcohol indicates an increased epilepsy risk also in more general terms. If the risk were to be realised, however, it would probably come up during a monitoring period of approx. two years. Shortening the driving ban duration following a seizure can be considered if the driver commits to abstinence and monitoring and refrains from intoxicant use as planned (e.g. controlled Antabuse treatment and regular breathalyser tests), and the symptoms of a seizure do not recur. Under the Directive on driving licences, a neurologist's assessment is also required.

The Driving Licence Act also currently gives nurses and public health nurses the right to notify the police if their patients include a driver who constantly uses intoxicants (see section 3.5.3).

F11 – F19 Harmful use of and dependence on drugs and medicinal products

As a rule, all drug abuse indicates increased risks, also to traffic safety; unlike alcohol consumption, using drugs is always illegal.

The medical standards of fitness to drive are not met if the driver is dependent on drugs, uses them regularly or abuses CNS agents. The requirements are also not met if the abuse of drugs or medicinal products has resulted in permanent health changes that impair the driver's fitness to drive or put driving safety at risk, affecting his or

her general functional ability, perception, judgement, reactions or behaviour. Such changes include permanent organic changes caused by drug or medicinal product abuse in the central nervous system or balance, impairment of cognitive functions or changes in personality or behaviour, for example.

In principle, healthcare professionals have a duty to notify the police of all Group 1 and 2 drivers who have a persistent intoxicant abuse disorder or untreated drug dependence or who abuse CNS agents. Nurses and public health nurses also have the right to notify the police if their patients include driver who constantly uses intoxicants (see section 3.5.3). The police may also require a driver caught driving under the influence (including intoxication caused by alcohol, medicines and drugs) to submit a medical report on his or her fitness to drive (cf. section F10 Alcohol).

A **Group 1** right to drive should be withdrawn for at least three months if the patient has had a verified seizure associated with using or withdrawal from drugs or medicines. Such symptoms as myoclonus are not regarded as a seizure unless disturbances in consciousness are present. If the seizure does not recur, there is no need to continue the driving ban.

If a **Group 2** driver has had a verified seizure associated with the use of intoxicants or medicines, a minimum period of five years without seizures is required as a basic premise before his or her right to drive can be reinstated. The police must also be notified. The same period of five years without seizures is also required when considering a new Group 2 right to drive. In this connection, too, it is important to ascertain that the patient no longer uses intoxicants.

If a CNS agent causes side effects such as tiredness and reduced alertness when the treatment is initiated, the medical standards of fitness to drive are not met for as long as these effects occur. In a patient on long-term medication, in particular, the treating physician should assess the effects of the medication on the patient's fitness to drive individually and regularly, taking into account his or her driving licence category and other state of health. A person can be considered to meet the medical standards of fitness to drive if he or she uses medicines according to a physician's instructions and the medication does not affect his or her alertness or other performance.

F12 Cannabis

The effects of cannabis use on fitness to drive should be assessed individually, taking into account such factors as the frequency of use and the driver's state of health in other respects. A driver is unlikely to meet the medical standards of fitness to drive at least if he or she uses cannabis regularly and more frequently than once a week. The requirements are not met if the driver cannot refrain from driving while intoxicated. From the perspective of fitness to drive, a driver should refrain from driving for 24 hours after a single event of using cannabis.

The impact on fitness to drive should also be taken into consideration when prescribing medicinal cannabis. As a rule, a patient who regularly uses medicinal cannabis may not drive.

Substitution treatments

A **Group 1** driver undergoing methadone or buprenorphine treatment must be banned from driving until the treatment stabilises and additional use of intoxicants or abuse of medicinal products no longer occur. If a person is applying for a **Group 2** right to drive for the first time and is already receiving substitution treatment, he or

she does not meet the requirements for fitness to drive. If the driver already has a Group 2 right to drive and is receiving substitution treatment, he or she may in exceptional cases be considered to fulfil the requirements, only if the treatment is in a stable phase as referred to in Ministry of Social Affairs and Health decree 33/2008 and additional use of intoxicants or abuse of medicinal products does not occur. This assessment must be made by the physician responsible for the substitution treatment. If the conditions described above are met, an early medical examination to monitor fitness to drive should be indicated on the form *Medical report on fitness to drive* or *Specialist medical report*. If the driver does not commit to the substitution treatment as planned or if additional use of intoxicants or abuse of medicinal products occurs, the police should be notified of his or her failure to meet the medical standards of fitness to drive.

F20 – F69 Other mental and behavioural disorders

A driver with a severe mental illness does not meet the medical standards of fitness to drive. However, the driver can, in certain cases be considered to meet the requirements based on a psychiatrist's assessment and regular repeat check-ups if necessary. The physician should take into account the increased risks associated with Group 2 drivers.

Regardless of the diagnosis, the medical standards of fitness to drive are not met and at least a temporary driving ban is required if the driver, despite treatment, has persistent psychological symptoms impairing driving cognition. This can mean, for example, that the driver's sense of reality, judgement and concentration or general functional ability have been significantly impaired. Psychiatric patients' fitness to drive should thus be assessed individually, and the effects of treatment should be monitored with sufficient frequency.

The situation should be assessed in light of information about the driver's behaviour in traffic, to the extent the physician has access to such information. The driver does not meet the medical standards of fitness to drive if he or she has repeatedly been involved or, based on other available information, is likely to be involved in verified hazardous incidents. Hazardous incidents are probable if a mental disorder is associated with a severe impairment of cognitive control and alertness, strong sensation-seeking behaviour and aggression and the change has persisted for a lengthy period with no response to treatment.

F32 – F34 Depression

Fitness to drive should also be assessed in connection with depression. Especially when prolonged, depression may cause changes in such areas as alertness, reaction speed and cognition, and it may also be associated with suicidal thoughts. Studies indicate that even a mild depression increases the risk of traffic accidents, and a severe depression means an up to four-fold risk.

A severe antisocial personality disorder, especially combined with dependence on intoxicants, is a major risk to traffic safety. In these situations, too, the assessment of fitness to drive is made individually, and it may not be exclusively based on the patient's diagnosis or medical treatment. The assessment should pay attention to psychopathology and the course of the disorder over a longer term as well as personality traits, of which especially impulsive, risky behaviour and problems with controlling aggression are in key role. In addition, the patient's awareness of the disorder and the effects of any somatic illnesses, medical treatment and intoxicants

on the patient's status should be taken into account. In these cases, a driving test is unlikely to produce significant additional information.

Both in Group 1 and Group 2, a temporary driving ban should be imposed (a longer ban for Group 2 drivers) if:

- The patient has a psychosis or mania, or a severe depression; in this case, the driving ban should cover at least the acute and active phase of the illness-.
- The patient is at a significant and immediate risk of suicide.
- The patient has begun taking strongly sedative medication; the driving ban should extend at least until the end of the medical treatment, or be continued until it has been ensured that the medication no longer has a significant sedative effect.

The police must be notified if:

- The patient's sense of reality, judgement or general functional ability have been impaired for a lengthy period (exceeding six months) to the extent that, regardless of treatment, he or she no longer meets the conditions for the right to drive (both in Group 1 and 2).
- The patient has an antisocial personality and he or she displays significant impulsiveness, a diagnostic indication of which is recurring hazardous traffic incidents, and there has been no response to the treatment of impulsive behaviour (both in Group 1 and 2).

Psychological disorders other than psychoses (excluding antisocial personality) do not usually reach a level where the notification duty would apply, apart from exceptional cases and following a thorough psychiatric examination. In particular, the notification duty applies to situations where verified hazardous incidents have occurred repeatedly, or where the occurrence of such incidents is likely based on other available information.

Self-destructive behaviour, especially suicidal ideation or attempts or plans to harm others in connection with driving a vehicle, require particular attention and are an indication for a driving ban.

The **suicide risk** associated with a psychiatric or other illness is always assessed individually:

- Suicidal ideation in a patient at a significant and immediate risk of suicide usually provides grounds for considering a driving ban for at most six months, which is not notified to the police.
- On patients who have planned to commit suicide using a vehicle in traffic or who have attempted suicide by such means, a driving ban of 6 to 12 months should be imposed (the notification duty applies).
- The driving permit may be reinstated if the disorder has improved essentially, the patient no longer has suicidal thoughts and he or she has given up their plans to commit suicide.

F70 – F79 Mental retardation

Group 1 medical standards of fitness to drive are met if the person has a mild mental retardation or even an extensive learning disorder that has not significantly prevented him or her from coping in basic education. Another requirement is that the mental retardation is not associated with other impairments in functional ability affecting fitness to drive, co-morbidities or behavioural disorders requiring attention. A favourable medical opinion on fitness to drive can be issued by a general

practitioner who is well familiar with the patient, his or her living conditions and the test results on which the diagnosis is based.

A **Group 1** driving permit can never be issued to a person with a moderate or severe mental retardation.

A **Group 2** driving permit can never be issued to a person diagnosed with mental retardation, regardless of the degree of severity. A report to this effect can be given by a general practitioner who is familiar with the patient if they have access to reliable information on the test results on which the diagnosis is based. The person may also fail to meet the medical standards of fitness to drive because of a co-morbidity associated with mental retardation (including visual impairment or epilepsy that is difficult to treat).

Special tests are required to assess fitness to drive in the following situations:

- The physician issuing the opinion suspects mental retardation or an extensive learning disorder but no reliable test results are available, or the matter has never been investigated.
- The person has a mild mental retardation or an extensive learning disorder that has been a major obstacle in basic education and/or is associated with a co-morbidity affecting fitness to drive or a behavioural disorder requiring attention.
- The person applying for a driving permit disagrees with the physician about the medical opinion on meeting the medical standards of fitness to drive.

In this case, it is recommended that the assessment of fitness to drive be carried out by a multiprofessional team consisting of a physician with expertise in mental retardation, a psychologist, an occupational therapist and an experienced driving instructor. To evaluate an individual case, a temporary assessment team can be composed of persons with expertise in assessing fitness to drive, or the assessment can take place at a clinic specialised in fitness to drive.

F84 Autism and Asperger's syndrome

Autism is one of extensive childhood developmental disorders, typical characteristics of which include severe and extensive deficiencies in social interaction and communication ability that already emerge in childhood. While the symptoms often become milder in adult age, autism is a permanent condition, and it may be associated with mental retardation. The assessment of fitness to drive should be carried out individually based on cognition (see section 4.1) and any mental retardation (see the previous section). In principle, a Group 2 driving permit cannot be issued to a person who has autism.

Asperger's syndrome (F84.5) is included in autism range disorders. The disorder is permanent, and its characteristics include an inability to understand other peoples' emotional states, consequent communication problems as well as different repetitive behaviours. Persons with Asperger's syndrome often continue to have problems in their close relationships as well as situations and occupations requiring interaction skills in adulthood. Unlike autism, however, this syndrome is not associated with significant retardation in cognitive verbal functions; on the contrary, many of those diagnosed with Asperger's are intellectually normal or even gifted. Asperger's syndrome does not necessarily affect fitness to drive, but the situation must be assessed carefully and individually based on cognition and behaviour.

F90 – F91 Hyperkinetic and other conduct disorders

These disorders are associated with various symptoms that may put traffic safety at risk. A hyperkinetic disorder is often related to proneness to accidents, carelessness in hazardous situations and impulsiveness. Conduct disorders, on the other hand, may be associated with antisocial, aggressive or even defiant behaviour.

ADHD

ADHD takes many forms, among other things because this condition is usually associated with significant co-occurring disorders, including intoxicant use or affective disorders. A mere attention deficit disorder causes a smaller risk to traffic safety than a condition associated with impulsiveness or sensation-seeking. Persons who have in the past repeatedly exhibited violent behaviour or other conduct disorders are at a particularly great risk. The symptoms are usually reduced in adulthood. While ADHD undermines traffic safety in general, this risk can be reduced by treatment. Appropriate medical treatment of ADHD, including stimulants, may even improve driving performance and is not as such a cause for refusing the driving permit.

The medical standards of fitness to drive are met if:

- the symptoms are mild and/or under appropriate control with or without medication.

The medical standards of fitness to drive are not met if:

- there is evidence of repeated risky behaviour or hazardous incidents, or their occurrence is likely
- the disorder is associated with severe impairment of alertness and strong sensation-seeking and/or impulsiveness
- the condition is associated with significant other cognitive function disorders (see section 4.1).

The medical standards of fitness to drive, especially for Group 2, can only be regarded as being fulfilled when the disorder is mild and under appropriate control.

G00 – G99 Diseases of the nervous system

G20 Parkinson's disease (and other parkinsonisms)

The fitness to drive of a Parkinson's disease patient varies, and it should consequently be assessed and monitored frequently enough and over a sufficiently long period. Drivers with a parkinsonism may also assess their own fitness to drive and coping in traffic unrealistically optimistically.

The notification duty related to **Group 1** drivers applies when the disease has progressed to a stage where the driver's reaction speed has significantly slowed down or he or she has a clear cognitive disorder, such as even a mild dementia, with obvious perceptual problems. A patient with minor variability in his or her status can keep driving. A patient with significant slowness of movements and variability in motor function should refrain from driving, at least on a temporary basis. The notification duty applies to these symptoms if optimal treatment has been unable to essentially reduce the symptoms or the condition persists for longer than six months.

In **Group 2** drivers, even smaller changes in the functions discussed above are an indication for a driving ban, and the notification duty applies.

If optimal treatment significantly improves the patient's motor function, a new favourable medical opinion can be issued for a fixed period to a driver in either group if this is also permitted by his or her cognitive function.

G30 - 32 Alzheimer's disease and other memory disorders (incl. F00 – 03 and I67.3)

Group 1 medical standards of fitness to drive are not met if the driver has a memory disorder that is at least moderate ($CDR \geq 2$) and affects his or her cognitive function. The notification duty also applies in this case.

A mild dementia or other memory disorder is usually diagnosed by a neurologist or geriatrician. Once diagnosed, the driver's fitness to drive is monitored and assessed by a neurologist, geriatrician or a general practitioner. A mild memory disorder ($CDR 0.5-1$) usually requires monitoring by a primary health care physician at six-month intervals. To assess fitness to drive, a driving test or a voluntary test of fitness to drive is used, if necessary.

The severity of a memory disorder can be assessed based on an MMSE score which, however, does not on its own give a sufficient indication of fitness to drive and functional ability, especially at the onset of the illness. Useful additional tests include CERAD and a neuropsychological examination.

Group 2 medical standards of fitness to drive are not met if the driver has been diagnosed with a memory disorder. The notification duty applies as soon as the driver's memory disorder has been confirmed, regardless of its severity. The reason for the impaired memory must have been investigated. In most cases, this is a progressive illness, which should be taken into account when monitoring fitness to drive.

G35 MS disease

The fitness of drivers with MS disease is assessed as indicated by their functional ability (muscular strength, coordination, balance, regulation of alertness). A neurologist's report is always required for an assessment of long-term fitness to drive. MS is a progressive disease, which should be taken into account when assessing and monitoring fitness to drive.

If MS is suspected in a **Group 1** driver, a temporary driving ban may be necessary, at least while tests are carried out, treatment is initiated and the patient's situation stabilises. If the disease was diagnosed earlier, it may be necessary to impose a temporary or permanent driving ban if the patient's symptoms, treatment or impairment of functional ability would likely constitute a danger to road safety.

A temporary driving ban should be imposed on a **Group 2** driver with suspected MS, at least while tests are being carried out and treatment is initiated. If the disease has been diagnosed earlier, as a rule, a favourable medical opinion should not be given.

G40 Epilepsy

When a **Group 1** driver has his or her first epileptic seizure, the physician imposes a temporary driving ban for three months if no other cerebral disease has been found in tests and the EEG results do not indicate epilepsy. If susceptibility to recurring epileptic seizures is diagnosed in tests, either based on several seizures or because the tests reveal an underlying illness making the patient susceptible to epilepsy or the EEG shows epileptic changes, the duration of the driving ban should be one year after the most recent seizure. The police should be notified of a driving ban

exceeding six months. If a progressive cerebral disease is found in tests (e.g. a malignant brain tumour or dementia), the duration of the ban may exceed one year.

When less than three years have passed since the previous epileptic seizure, a 12-month driving ban is imposed following each new sporadic seizure. If more than three years have passed since the most recent seizure, the length of the driving ban should be six months. A driving permit is usually issued for a fixed term to a Group 1 driver.

If the patient has a seizure caused by reductions in dosage or phasing out of epilepsy medication following a physician's instructions, a driving ban of three months should be imposed. However, imposing a proactive driving ban while dosage is reduced or the medication phased out is not necessary.

While epilepsy rarely requires Group 1 drivers to give up driving permanently, unfitness to drive for more than six months is not considered temporary and must be notified to the police. The physician may recommend that the right to drive be reinstated once the driver has not had seizures for a minimum of 12 months.

When assessing fitness to drive, it should be remembered that some epilepsy patients are not only susceptible to seizures but may also have for example cognitive and psychiatric disorders, which may affect their fitness to drive.

If a **Group 2** driver has his or her first or an isolated epileptic seizure, a driving ban of five years is imposed, and the police should be notified of the driver's failure to meet the medical standards of fitness to drive. If the driver has no seizures during these five years with no medication, he or she meets Group 2 health requirements. The patient's prognosis regarding epilepsy and the length of the driving ban should always be assessed by a neurologist.

Epileptic seizures

As a rule, the above instructions apply to all epileptic seizures, regardless of their nature or time of occurrence. Seizures occurring during sleep are considered equal to those the patient has during waking hours. The same instructions are followed even if the person did not experience a significant loss of consciousness during the seizure. At a neurologist's discretion, an exception may be made in case of minor myoclonic symptoms without loss of consciousness. A driving ban should be imposed even if the seizures were provoked by intoxicant use, lack of sleep or not eating, even if the patient says he or she is trying to live healthier. If an isolated seizure was provoked by a drug lowering the seizure threshold or other temporary factor that can be avoided or eliminated, a neurologist may consider this as a factor for shortening the duration of the driving ban.

A favourable medical opinion should not be issued to a patient applying for his or her first Group 2 driving licence if he or she has acute epilepsy. If a patient is diagnosed with epilepsy (either two or more seizures, or an underlying illness discovered in tests following an isolated seizure), the notification duty applies. In this case, the driver can only meet the Group 2 medical standards of fitness to drive when ten years have elapsed from the most recent seizure without medication.

Under the EU Directive on driving licences, a driving ban is justified in certain cases if the calculated annual seizure risk is over 2 per cent, even if the patient has not had a single seizure. These situations include the sequelae of brain injuries and brain surgery as well as encephalitis cases. In these situations, a neurologist or a neurosurgeon should assess the length of the driving ban as a whole, taking into

account not only the seizure risk but also potential cognitive disorders, among other things.

G45 TIA

In case of even a transient ischemic attack, a driving ban of at least one month must always be imposed. The length of the driving ban depends on the risk of recurrence, for example.

A **Group 1** driver should be banned from driving for at least one month after an isolated TIA attack, or longer depending on the risk of recurrence of similar or more severe attacks. The risk can be evaluated on the ABCD2 or CHA2DS2-VASc scale, for instance. For high-risk patients, the length of the driving ban should be at least three months. A high risk caused by some other reason may additionally necessitate a longer driving ban than this, for example, when the patient has a known cause of embolism, intracranial arterial stenosis or susceptibility to blockages if the risk of their recurrence cannot be lowered by treatment.

After an isolated TIA attack, a driving ban of at least six months should be imposed on a **Group 2** driver. If there is a high risk of recurrence or a further TIA attack, the driving ban should be longer or permanent. In both cases, the police must be notified.

G47 Organic sleep disorders

G47.3 Sleep apnoea

When assessing a sleep apnoea patient's fitness to drive, his or her degree of tiredness in waking hours is crucial. An ESS questionnaire, which charts the sleepiness symptom, and the AHI index describing the severity of the sleep apnoea disorder have a low correlation to sleepiness and the risk of traffic accidents. When the AHI index is 5 to 15 without symptoms of sleepiness, the sleep apnoea is unlikely to be a problem while driving. If the AHI index is over 15, lack of alertness may cause problems while driving and a more detailed objective evaluation of alertness is needed, such as an MWT, Osler or voluntary test of driving ability to evaluate alertness. The situation should always be considered as a whole and on its individual merits, and if necessary, a physician with expertise in disorders of sleep and alertness should be consulted.

For a **Group 1** driver, issuing the right to drive must not be recommended if they have a severe tendency to fall asleep caused by sleep apnoea. Until the treatment response has been established, a temporary driving ban should be imposed if the driver has a severe tendency to fall asleep. If an adequate treatment response has not been achieved in six months, a notification of unfitness to drive must be made to the police.

The effect of CPAP or other treatment of Group 1 drivers with sleep apnoea and their compliance with treatment should be monitored regularly with at least three-year intervals.

For **Group 2** drivers, even a milder impairment of alertness caused by sleep apnoea can prevent them from receiving the right to drive. The referring physician should already impose a verbal driving ban if the patient has already been involved in a traffic accident or a near miss or $ESS \geq 15$, or if the physician has other grounds to consider that the standards of fitness to drive are not met. In specialised health care, a voluntary test of driving ability, an MWT, Osler or a driving simulation test of at least 90 minutes should be conducted according to local practice after one or two

months of CPAP use, with a verbal driving ban imposed until that time regardless of the type of driving licence. If, based on the test result, the state of health is sufficient for driving and the treatment of sleep apnoea is at least satisfactory, the verbal driving ban can be repealed. The police should be notified of the driving ban if the alertness disorder, even if mild, has not improved over six months of treatment and an alertness disorder has been confirmed.

If an independent sleep apnoea nurse suspects that a patient does not meet the standards of fitness to drive, the nurse instructs the patient not to drive, enters it into the patient record, notifies the patient's physician in occupational health care/health centre about the issue and asks the patient to reserve an appointment with said person soon. The nurse can also consult the responsible physician in specialised health care about further measures in accordance with the local instructions.

Abnormal tiredness during the day refers to $ESS \geq 10$ or if the patient is tired during the day when activity is low and the situation requires moderate focus (such as driving a car, participating in a meeting, watching movies).

Abnormal tendency to fall asleep

For example, the following questions can be used to assess the tendency to fall asleep:
How often has the driver:

- felt tired while driving?
- had near misses while driving?
- had a traffic accident because of tiredness or falling asleep at the wheel?

The effect of CPAP or other treatment of Group 2 drivers with sleep apnoea and their compliance with treatment should be monitored regularly with at least one-year intervals.

Sleep apnoea and driving professionally

If the driver's $ESS < 10$ and the driver does not suffer from unusual tiredness during the day, and there are no other factors affecting the fitness to drive negatively in addition to the sleep apnoea, the driver has not been involved in a traffic accident or a near miss situation and the voluntary test of driving ability or other test evaluating alertness is normal, the driver is allowed to continue driving regardless of AHI. If a suspicion arises on the weakening of the patient's cognitive ability, a neuropsychological examination is also conducted, Repeating the alertness test after a year should be considered.

G47.4 Narcolepsy

In other disorders of sleep and alertness, including narcolepsy, information is needed especially about alertness during waking hours, tendency to fall asleep and treatment. All situations must be considered case by case, and a neurologist specialising in sleep and alertness disorders should be consulted.

The notification duty applies if a **Group 1** driver has a severe tendency to fall asleep during waking hours, the driver does not respond to treatment and the tendency continues for at least six months.

A **Group 2** driving licence can never be issued to a person with narcolepsy.

Severe chronic respiratory failure

A severe chronic respiratory failure is sometimes associated with severely reduced alertness in waking hours and impairment of memory functions, which may affect fitness to drive. For more information, see section J00 – J99 Respiratory diseases.

H49 – H53 Disorders of the eye

H49 - H51 Eye movement disorders, strabismus and diplopia

If a driver has recently started experiencing double vision, he or she does not meet the medical standards of fitness to drive. The reason for diplopia (eye-related/neurological) must be investigated and reports must be obtained from specialists of the relevant field (e.g. neurology, ophthalmology). The medical standards of fitness to drive can be met again once the diplopia has disappeared.

In **Group 1**, if the diplopia persists for six months, a precondition for meeting the medical standards of fitness to drive is adapting to double vision (as assessed by an ophthalmologist or a neurologist) and passing a driving test. If the driver has not adjusted to the situation or fails the driving test, the police must be notified.

A **Group 2** driver can never retain their right to drive if they have diplopia.

H52 Disorders of refraction

Examination of eyesight

A driver's eyesight is examined without glasses and with his or her usual glasses for distance vision, using an approved chart and over the distance given in the chart, in good lighting conditions, and without background light causing a glare. The test is conducted first separately with each eye and then with both eyes together. If the chart has several visual acuity scales, the scale intended for each distance should be checked. In Group 2, the strength of the corrective lens may not exceed +8 dioptres in either eye. The binocular visual acuity should not be presumed to be better than that measured separately for each eye, as the eye with poorer vision may impair the acuity of the better eye. If the visual acuity does not meet the requirements and an inadequately corrected disorder of refraction is suspected as the cause of this, the driver should have his or her eyes checked by an optician or an ophthalmologist, after which the examination for the driving licence can be completed.

In **Group 1**, binocular visual acuity must be at least 0.5, with corrective lenses if necessary. If the applicant has lost vision in one eye or only uses one eye for visual observation, he or she must have a visual acuity of at least 0.5, and this condition must have existed for a sufficiently long time to allow adaptation to only using one eye. If key requirements of visual acuity are not met, a driving ban must be imposed. Even a medical report and a completed driving test do not allow derogation from the ban.

If the patient has recently lost sight in one eye, the police must be notified. A new ophthalmologist's assessment of meeting the medical standards of fitness to drive can be carried out at the earliest six months after the loss of sight. During this interval, the health requirements are not met. In order to meet the requirements once more, the driver also has to pass a driving test.

In **Group 2**, the visual acuity must be at least 0.8 in one eye and 0.1 in the other (if necessary, with corrective lenses of no more than +8 dioptres; when contact lenses

are worn, this limitation does not apply). If key requirements of visual acuity are not met, a driving ban must be imposed. Even a medical report and a completed driving test do not allow derogation from the ban.

Lens strength vs. spherical equivalence

The Directive on driving licences only refers to the strength of corrective lenses in dioptres (not exceeding +8 D). This definition does not account for astigmatism; when this condition is accounted for, the final lens strength (spherical equivalence) can be different from the mere dioptric correction. Spherical equivalence = spherical correction with a +/- sign ($\pm D$) + cylindrical correction with a +/- sign, divided by two. For example, for correction of +7.5 cyl + 1.5 ax 0, the spherical equivalence is +8.25, while for +8.25 cyl - 1.0 ax 90, the spherical equivalence is +7.75. In unclear and borderline cases, an ophthalmologist should be consulted if necessary.

If the patient has severe visual impairment in one eye or has lost binocular vision, an ophthalmologist must re-assess whether or not the person meets the medical standards of fitness to drive at the earliest three months after the impairment of vision. During this interval, the medical standards of fitness to drive are not met. In order to meet the requirements once more, the driver also has to pass a driving test.

Loss of vision and severe visual impairment

The WHO classification can be relied on in the determination of driving vision. As the limit for *vision loss* can be considered visus 0.1. If the vision is poorer than this, achieving adequate driving vision with usual optical devices is unlikely or difficult. As the limit for *severe visual impairment*, on the other hand, can be considered visus 0.3.

H53.4 Visual field defects

In **Group 1**, the binocular horizontal visual field must be at least 120 degrees. The extension should be at least 50 degrees left and right and 20 degrees up and down. No absolute defects should be present within a radius of the central 20 degrees regardless of the cause/aetiology.

If the visual field requirements are not met, investigations are needed to determine if the cause of the defect is eye-related or neurological. In case of **eye-related** causes, a favourable medical opinion can in some cases be given based on an ophthalmologist's report if the driver does not have any other impairments of visual function, including increased glare sensitivity, problems with twilight vision and significantly reduced contrast sensitivity. In case of visual field defects caused by glaucoma, for instance, an ophthalmologist may give a favourable medical opinion if the defect is minor and examined by means of a computer-aided visual field test, no impairment is found in other areas of vision (central vision, glare sensitivity, contrast sensitivity, twilight vision) and the person passes a driving test.

If the visual field defect is caused by a **neurological** reason, the driver must be examined by a neurologist and, if necessary, also a neuropsychologist. A favourable medical opinion may be given at the physician's discretion if the neurological visual field defect does not exceed a quadrant and does not reach a central area. In the report issued on the examination, a recommendation of taking a driving test or a voluntary test of fitness to drive should be included, if necessary. The ophthalmologist evaluates in their report the extent and significance of the visual

field defect, and if the requirements on visual health are not met, notifies the police that the standards of fitness to drive are not met. A homonymous hemianopia or quadrantanopia is an obstacle to driving.

Examination of visual fields

Any visual field defects in a driver who is presumed to be healthy can be examined by means of carefully performed finger perimetry. The visual field examination should cover the visual field areas required for Groups 1 and 2 mentioned above. The examination may reveal both absolute and partial (relative) defects. Absolute defects are crucial in terms of assessing the fulfilment of medical standards of fitness to drive. No absolute defects may be present within a radius of the central 20 degrees. Minor relative visual field defects found in a computer-aided test (at most one absolute defect the size of a normal blind spot) in the binocular visual field alone does not mean that the driver fails to meet the visual field requirements; the decisive factor is the overall assessment of his or her vision (other illnesses affecting perception, night vision, contrast vision).

When the visual field defect is caused by a neurological illness (e.g. a cerebral infarction), a report from not only an ophthalmologist but also a neurologist is required. Especially the findings of the neuropsychological examination are taken into account in the neurological investigation. If a neurological illness causes even a mild cognitive impairment in addition to the visual field defect, it is likely that the medical standards of fitness to drive are not met. As a rule, a driving permit cannot be issued to a patient with a neglect symptom.

In **Group 2**, the binocular horizontal visual field must be at least 160 degrees. The extension must be at least 70 degrees left and right and 30 degrees up and down. No absolute defects should be present within a radius of the central 30 degrees. No exception can be made from the visual field requirements in any situation.

Disorders of contrast vision

Examination of contrast vision

Carrying out screening and routine examinations of contrast vision in primary healthcare is often not practical. Moreover, no specific or standardised method exists for examining contrast vision. The examination is necessary, however, especially for Group 2 drivers if there is reason to suspect any problems in this area. An assessment of contrast vision and its effects on driving vision is carried out as part of the overall assessment, and an ophthalmologist should be consulted if necessary. Many illnesses of the eye (cataracts, glaucoma, vitreous floaters, retinal diseases and especially macular degeneration) may impair contrast vision and affect the fulfilment of vision-related requirements.

An exception can be made to the visual field requirements for Group 1 drivers based on an ophthalmologist's report if the driver does not have any other disorders of visual functions, including increased glare sensitivity, lowered contrast sensitivity or problems with twilight vision. In Group 2, a person with significantly lowered contrast sensitivity or twilight vision fails to meet the vision-related requirements.

Old exemptions from requirements on eyesight and the visual field

Old exemptions from eyesight requirements granted by an authority (Driving Licence Act, section 107)

Old exemptions from eyesight requirements granted by the Finnish Transport Safety Agency that remain valid can still be renewed today on certain conditions. **New exemptions from eyesight requirements are no longer granted.**

An exemption from the eyesight requirements granted for a fixed term remains valid, regardless of the period of validity indicated, if the conditions of the exemption are otherwise met. The prerequisite for this is that the driver's vision has not deteriorated since the previous exemption was granted. The driver must prove to the **police** that the conditions of the exemption are met by presenting an ophthalmologist's report at the latest within five years of the exemption's expiry date and, subsequently, at the minimum intervals of five years unless a shorter interval is indicated in the ophthalmologist's report or the earlier expiry of the driving licence.

Old requirements on the visual field (Driving Licence Act, section 112)

The right to drive granted before the day when the act entered into force remains valid, if the party with the right to drive meets the health requirements that were valid when the driving licence was granted. However, the act does not prevent the current requirements on the visual field from being applied to a right to drive granted before 1 October 1990, if the defect, illness or disability in connection with the defect in the visual field or other changes that have occurred in the visual field materially reduce the ability to drive a vehicle.

H60 – H95 Diseases of the ear

H81 Ménière's disease and other disorders of the vestibular organ

Vertigo caused by Ménière's disease or other reasons may necessitate at least a temporary driving ban, especially if the symptoms are severe, recur frequently or begin suddenly. Ménière's disease may also be associated with other symptoms impairing functional ability and fitness to drive, including loss of muscular power or balance. The length of the potential driving ban depends on the severity of symptoms and the treatment response.

H90 Hearing loss

No requirements related to hearing apply to **Group 1**.

In **Group 2**, the medical standards of fitness to drive are met in principle if the applicant's hearing is sufficient for communication and observing the environment. According to the Directive on driving licences, special attention must be paid to compensating for the deterioration of hearing. In fact, sufficient hearing can also be achieved with a hearing aid or a cochlear implant. More specific hearing requirements may be placed on professional drivers by their work, however, which should be noted when choosing the field and assessing work ability.

In both groups, it should be ascertained that a person affected by hearing loss can hear or understand adequately the questions asked by the physician examining them.

I00 – I99 Diseases of the circulatory system

I10 Hypertension

Under the Directive on driving licences, the medical standards of fitness to drive are not met if:

- a **Group 1** driver has malignant hypertension (elevation in systolic blood pressure ≥ 180 mmHg or diastolic blood pressure ≥ 110 mmHg) associated with impending or progressive organ damage
- a **Group 2** driver has systolic blood pressure ≥ 180 mmHg or diastolic blood pressure ≥ 110 mmHg.

Driving licences may be issued or renewed only after the condition has been effectively treated and monitored regularly.

I20 Coronary artery disease: Chest pains, angina pectoris and shortness of breath

The risk of functional ability loss and sudden death is the greater, the lower the level of physical strain that causes the person angina pectoris pain, shortness of breath or some other symptom limiting their performance. By refusing driving permits to persons with serious cardiovascular diseases, an attempt is made to reduce the damage caused by drivers' sudden deaths. The degree of severity of coronary disease (CCS class) should be evaluated as part of assessing fitness to drive.

When assessing fitness to drive, sequelae of a coronary bypass and angioplasty as well as angina pectoris are medically comparable to a myocardial infarction in terms of their risks. The fulfilment of medical standards of fitness to drive is monitored at regular medical check-ups. If the patient has been transferred to primary healthcare for treatment and monitoring, the check-ups can be carried out by a primary healthcare physician. The interval of check-ups is individual.

It is recommended that a favourable medical opinion on renewing the right to drive be given to a Group 2 driver with coronary disease for a period decided at the physician's discretion, however not exceeding five years. A clinical stress test is carried out if necessary. The patient is referred to an examination by a specialist if he or she has chest pains or shortness of breath when rushing, engaging in physical activity/work or during other physical efforts. While a driver with cardiac symptoms is undergoing investigations, the physician must in most cases impose a temporary driving ban.

Drivers with coronary artery disease may be issued with or refused a driving permit on the following conditions:

The medical standards of fitness to drive in **Group 1** are not met if the driver has chest pains or shortness of breath when at rest, washing oneself, getting dressed or during some other minor physical activity, or when under emotional strain (CCS class 4).

The medical standards of fitness to drive in **Group 2** are not met if the driver has cardiac symptoms (chest pains or shortness of breath) when walking on the flat at an ordinary pace, during physical activity less strenuous than this (at rest, washing oneself, getting dressed) or when under emotional strain (CCS classes 3 and 4).

The medical standards of fitness to drive are met if the driver's performance is normal or at most slightly reduced (CCS 1–2), normal or at most slightly reduced

performance is found in a clinical stress test, and no diagnostic changes indicating ischemia, serious arrhythmia or circulatory changes caused by ischemia are found.

I47 – I49 Arrhythmia and conduction disturbances, loss of consciousness (R55)

A driver with a serious arrhythmic condition does not meet the medical standards of fitness to drive. A serious arrhythmic condition refers to recurring arrhythmias that have a significant effect on the level of consciousness or functional ability and cannot be corrected by medical treatment or invasive procedures.

If they have experienced a sudden loss of consciousness (syncope), drivers in both groups are disqualified from driving until the cause of the syncope has been uncovered and the symptoms are under control. After a typical vasovagal collapse, a favourable medical opinion can be given to a Group 1 driver without further examinations or monitoring. A specialist examination (by a cardiologist/endocrinologist/neurologist) is necessary if the cause of the syncope has otherwise not been found and treated. After the tests, the patient may drive if no reasons impairing his or her fitness to drive are found, or if the cause for the loss of consciousness is found and treated and the driver has been asymptomatic for three months. In this situation, the police is not notified.

Pacemaker (Z95)

After pacemaker implantation, a specialist in the relevant area (usually a cardiologist) assesses whether the driver meets the medical standards of fitness to drive. The fulfilment of the health requirements must be monitored in the future.

If the driver has no symptoms following pacemaker implantation, he or she can be considered to meet the medical standards of fitness to drive. The treating specialist decides the interval of the pacemaker patient's medical check-ups on an individual basis. The medical standards of fitness to drive are not met if the patient continues to have symptoms affecting their level of consciousness and functional ability after pacemaker implantation. If the unfitness to drive lasts for at least six months, the police must be notified.

After the implantation of a defibrillating pacemaker (AICD), the treating cardiologist assesses whether a Group 1 driver meets the medical standards of fitness to drive based on the indications of the pacemaker implantation. A favourable medical opinion should not be issued to a Group 2 driver who has indications of AICD implantation.

I50 Heart failure

The medical standards of fitness to drive are met:

Group 1

NYHA I, II, and III heart failure with stable symptoms.

Group 2

NYHA I, provided that the left ventricular ejection fraction is at least 35 % and there are no symptoms, the patient does not have serious arrhythmias, his or her physical performance is normal or at most slightly impaired in a stress test carried out while the patient is on medication, and no arrhythmia develops during physical activity.

Heart valve disorders (I 34–39), cardiomyopathies (I42), congenital cardiomyopathies and hereditary heart defects, sequelae of heart transplantation

The fitness to drive is assessed individually (see attached table).

I60 – I69 Cerebrovascular diseases

A cerebral infarction or brain haemorrhage in **Group 1** drivers usually results in a driving ban for at least three months. If the patient is asymptomatic with no abnormal status findings and the risk of recurrence is low, the situation can be equated to a TIA attack. If the risk of recurrence is high or the patient has symptoms or findings affecting fitness to drive after the acute phase, the length of the driving ban usually is at least six months, and if the risk of recurrence of a cerebrovascular event has been assessed as permanently elevated, this may also mean a permanent driving ban.

After an isolated cerebral infarction or brain haemorrhage, a **Group 2** driver is always banned from driving for at least six months. The notification duty also applies in this case. After having a cerebral infarction or a brain haemorrhage, a driver may only be allowed to drive if he or she only has mild symptoms and no significant abnormal findings, and the risk of recurrence is estimated low.

A driver with a visual field defect caused by a cerebrovascular disease is usually banned from driving. An exception to this rule can only be made in carefully restricted cases. For more information, see section H53.4 Visual field defects.

Neuropsychological findings and cognitive disorders, in particular perceptual disorders but also problems with cognitive control, slowness of processing and alertness disorders, are in key role when assessing fitness to drive. For more information on the significance of cognition, see section 4.1 Cognitive fitness to drive. As a rule, a driving permit cannot be issued to a patient with a neglect symptom. A driving test may be useful for conducting the assessment. The driving ban can sometimes be lifted at the end of the convalescence period if symptoms or findings affecting fitness to drive no longer exist and the risk of recurrence is considered low.

J00 - J99 Respiratory diseases

J96 Respiratory insufficiency (incl. J44 chronic obstructive pulmonary disease (COPD))

Respiratory insufficiency and hypoxemia caused by different reasons may affect alertness, cognition and the ability to drive. Hypoxemia weakens neuropsychological functions, such as focus, short-term memory, learning, motor speed and linguistic fluency. Patients suffering from respiratory insufficiency often also have other diseases that may weaken the ability to drive.

Even stable COPD may weaken the ability to drive. In fact, a structured assessment of cognition should be a part of the assessment of fitness to drive of a COPD patient.

A pulmonary specialist should assess whether the standards of fitness to drive are met if $SpO_2 < 90\%$ at rest or if $FEV_1 < 30\%$ of the expected value. The assessment of standards of fitness to drive applies to the following patient groups: severe COPD or otherwise impaired oxygen saturation, a clinical suspicion that muscular strength has weakened, deteriorated performance or weakened cognitive ability. When carrying out the assessment of standards of fitness to drive, the arterial blood gas sample is taken while the patient is seated. If there is a clinical suspicion that the patient's cognitive fitness to drive has deteriorated, neuropsychological tests must be considered. The goals of $pO_2 > 7.3$ kPa and $pCO_2 < 6.7$ kPa must be met either with bi-level positive airway pressure at night or oxygen concentrator treatment.

Voluntary testing of driving ability can be used, if after the tests and instructions above a suspicion of the patient's overall fitness to drive remains or if there is a clear conflict between the physician's and the patient's opinions. The duration of the test must be long enough (max. 90 min), that a pulse oximeter can detect a potential decrease in oxygen saturation ($SpO_2 < 90\%$). This often occurs rapidly when driving becomes a bit more challenging. The driving instructor conducts the rest of the assessment of driving ability.

S06 and T90 Brain injuries, sequelae of brain injuries and neurosurgical procedures

In sequelae of brain injuries or neurosurgical procedures, the patient's cognitive ability and potential post-injury personality changes (frontal lobe syndrome) are key to fitness to drive. For more information on the significance of cognition, see section 4.1 Cognitive fitness to drive. Immediately after sustaining the injury, a driving ban of one month is recommended for drivers with a mild brain injury, three months for those with moderate injuries and six months where the injury is severe. In the latter case, the police is always notified.

In stable cases, the notification duty concerning a **Group 1** driver may apply to sequelae of a severe brain injury in which the disability category is 11 to 15 (disability classification approved by the Ministry of Social Affairs and Health). These patients may have moderate or severe symptoms and changes of functional ability, including an impairment of cognitive functional ability resulting in significant disability, as well as neurological deficiency symptoms and epileptic seizures. In case of an extremely severe sequelae of brain injury (disability category 16 or over), a long-term driving ban and a notification to the police are required.

In case of **Group 2** drivers, the police should be notified if the sequelae of a brain injury is at least moderately severe, with a disability category of 6 or higher.

NB! The link between the driving permit and disability categories is for reference only. An exception to it may be made, for example when the disability category is to a major extent caused by a disorder not relevant to fitness to drive, including difficulties in producing speech.

6 Parking card for people with disabilities

A parking card for people with disabilities may be granted for persons with severely reduced mobility or for the purpose of transporting persons with severely reduced mobility who have a visual impairment or whose mobility is impaired by their disability. The impediment caused by an illness, injury or disability must prevent the person from walking independently and the disability category caused by it must be at least 11. If the disability results from impaired vision, the visual acuity in the better eye may not exceed visus 0.1, or an overall assessment of the binocular vision must correspond at least to disability category 17.

The essential point is whether the illness, injury or disability prevents the person from walking independently, not the nature of any assistive device they use. A person can be considered to walk independently even if he or she uses a walking stick, crutches or a rollator for support. In principle, a wheelchair user is not regarded as being capable of walking independently. A person with a severe chronic obstructive pulmonary disease or heart disease, for example, may meet the criteria for a disabled parking permit if the disability category requirement for the parking card is fulfilled and the person's mobility is severely reduced.

A parking card for transporting a person with severely reduced mobility may be issued if the person requires regular transport and cannot manage without an assistant after arriving. Even if the person were physically able to walk independently, walking independently or moving around safely may be prevented by some other reason. This may apply, for instance, when aspects of intellectual disability, an autism range condition or a severe memory disorder affect the person's ability to understand hazardous situations in parking areas, or the person has major problems with their social functional ability. In other words, these persons need to be supervised at all times, and when transported, they need an assistant.

For example, parking cards have been granted:

- To transport a Down's syndrome child with severe intellectual disability; even if the child's level of physical mobility is good, their disability category is 11 or higher. The child is highly impulsive and inclined to run away, and moving outside the home with the child is very challenging. When the child needs to use services, transport by car is required, and in order to avoid hazardous situations, it must be possible to park the car as close to the services as possible.
- For transporting a person with Asperger's syndrome, major problems with their social functional ability and an intellectual disability. They cannot go anywhere without an assistant, and their disability category is 11.
- For transporting an autistic person who may act impulsively and cannot go anywhere without an assistant and supervision; their disability category is 13.

To apply for a parking card for people with disabilities, a medical report is drawn up on form *F123, Medical report for a parking card for people with disabilities*. When issuing the report, the person's reduced mobility, disability, functional ability and need for supervision should be assessed as a whole. In practice, a person with reduced mobility who cannot go out without an assistant fulfils the Road Traffic Act definition of not being able to walk independently. Under the Decree (Government Decree on the requirements for granting a parking card for people with disabilities 471/2020), the person's disability category must be at least 11. The physician must express an opinion in the report on the applicant's status and the duration of the permit to be applied for (fixed-term/permanent). The parking card is issued for a maximum of 10 years at a time.

The disability category resulting from impaired vision or reduced mobility is determined according to the disability classification referred to in the Workers' Compensation Act (459/2015, section 84) and the Government Decree on the Disability Classification Referred to in the Workers' Compensation Act (768/2015). In particular, take note of the definition of determining the combined disability category.

- Workers' Compensation Act
 - www.finlex.fi/fi/laki/alkup/2015/20150459
- Government Decree on the Disability Classification Referred to in the Workers' Compensation Act
 - www.finlex.fi/fi/laki/alkup/2015/20150768

The physician hands the report to the applicant, who submits it to Ajovarma with the application or attaches it to an electronic application in Traficom's e-service.

When a person applies for a parking card for people with disabilities, the physician should at the same time assess if the person meets the medical standards of fitness to drive. Even if the person being examined is not able to drive, a parking card for people with disabilities can still be granted, if the vehicle is driven by another person.

7 Exemptions from the obligation to wear a seat belt and a safety helmet

Under the Road Traffic Act (729/2018, section 93) a person can be exempted from the obligation to wear a seat belt, other safety device associated with the seat, or a safety helmet if a health-related reason prevents them from using these safety devices.

This exemption should not be granted without weighty reasons, and not primarily on a patient's request; this should be a very rare and exceptional procedure. In order for an exemption to be granted, there must be a weighty health-related reason that makes using the safety device factually impossible or dangerous, or means that using the safety device would likely be a greater risk to the person's health or safety than the potential consequences of not using the safety device. Not using a seat belt can also pose a risk to the other passengers of the vehicle in case of an accident, for example. In this context, the person's fitness to drive should also be assessed from the perspective of safety, and alternatively, the need for a driving ban should be considered. An exemption cannot be used to make up for an impairment of sensory functions or mobility caused by such reasons as ageing or an illness.

The exemption is granted in a freely worded medical report, in which the reason for and period of validity of the exemption should be noted. Rather than sending the report anywhere, the driver should keep it with him or her while driving and present it to a supervisory authority if necessary.