



INSTRUCTIONS:

- Please provide all of the information requested in **Parts 1 through 3** below, and sign and date the form.
- This form is provided for use by a physician, physician assistant, or nurse practitioner to report an individual whose driving ability may be affected due to some physical or mental impairment.
- This form must be completed and signed by a licensed physician, physician assistant or nurse practitioner.
- Attach a sheet of your stationery (showing your letterhead), or a voided or blank prescription form, as additional verification for this statement, and mail the completed form with the attached stationery or prescription to: Medical Review Unit, New York State Department of Motor Vehicles, 6 Empire State Plaza, Room 337, Albany, NY 12228.
- If additional assistance is needed, please contact the Medical Review Unit at (518) 474-0774, option #3. Hours are 8:30 am to 12:00 pm.
- If your patient is an older driver, you may also visit the Resources for the Older Driver website at dmv.ny.gov/olderdriver.

Please Note: Based on the medical information submitted, our reviewer may ask for further medical details, or may request additional information from a pertinent sub-specialist, ex: cardiologist; neurologist

PART 1 - DRIVER IDENTIFICATION (please print)

			Driver License Number		
Last Name*		First Name*		M.I.	Date of Birth (if not known, give approximate age)
Street Address					
City*				State	Zip Code

* Required information

PART 2 - DESCRIPTION OF THE DRIVER'S CONDITION

Have you treated this patient? YES NO

If Yes: Date of Last Examination? _____.

Please describe the condition that you have treated or are currently treating:

Is the patient receiving medication for this condition? YES NO

If Yes: Please specify the type and dosage:

In my medical opinion, (please check one):

the patient's condition may affect the safe operation of a motor vehicle, and the patient should be evaluated by the Department of Motor Vehicles

the patient's condition prevents the safe operation of a motor vehicle and driving privileges should be suspended.

Please provide further detail in the space provided or in an attached statement on your letterhead:

PART 3 - IDENTIFICATION AND CERTIFICATION OF THE PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER COMPLETING THIS REPORT

Your name (Print name in full)		Certificate or Lic. No.	Specialty (Please specify)	
Your Mailing Address (Include Street & No.)				State Where Licensed
City	State	Zip Code	(Area Code) & Telephone Number ()	
Your Signature (Sign name in full)				Date (Month/Day/Year) / /