



INSTRUCTIONS:

- This form is to be used by concerned citizens to report a driver who appears to be unable to drive safely.
The Department will not act on your request unless you complete all four parts below and on Page 2, and provide all required information.
Sign the completed original form and mail it to: Medical Review Unit, New York State Department of Motor Vehicles, 6 Empire State Plaza, Room 337, Albany, NY 12228
Be aware that the review you are requesting may lead to the suspension or revocation of the driver's license of the person you are reporting.

PART 1 - Identification of the person whose ability to drive is in question (Please print.)

Form with fields: Last Name (Required), First Name (Required), M.I., Date of Birth (if not known, give approximate age) - (Required), Street Address (Required), City (Required), State (Required), Zip Code, Make of Vehicle the Person Normally Drives, Color of Vehicle, License Plate Number

PART 2 - Your identification (Please print.)

A representative of the NYS DMV may contact you concerning your request for driver review.

Form with fields: Your Name (Print name in full) - (Required), Your Date of Birth (Required), Client ID No. (9-digit number from your NYS Driver License or Non-Driver ID card), Your Home Address (Include Street & Number) - (Required), City (Required), State (Required), Zip Code (Required), Your Daytime Telephone Number (Area Code) - (Required)

Your relationship to the driver you are reporting:

- Daughter, Son, Sister, Brother, Spouse, Mother, Father, Neighbor, Other (explain)

PART 3 - Your reasons for reporting this driver

Explain why you feel the person you identified in Part 1 should have his/her driving abilities reviewed. Be as specific as possible, and include specific incidents, observations, dates, locations, etc.

**PART 3 - (Continued from Page 1)**

If you know other people who agree with your assessment of this driver, who DMV may contact, please identify them below:

Name	Address	Daytime Telephone Number
Name	Address	Daytime Telephone Number
Name	Address	Daytime Telephone Number
Name	Address	Daytime Telephone Number

**PART 4 - CERTIFICATION:**

I certify that the information I provided above is true and accurate. I understand that any false statement given by me may be punishable by law.

X

\_\_\_\_\_  
(Your Signature - Sign name in full)

\_\_\_\_\_  
(Date - Month/Day/Year)

