



To Our Driver License Customer:

Your healthcare provider (physician, physician assistant, or nurse practitioner) must complete and sign this form.

IMPORTANT: The information provided on this form must be from an examination of you that was done by your health care provider within the last six months.

All medical documents received by the DMV are treated as personal and confidential information.

Thank you for your help.
Department of Motor Vehicles

..... DOWN ARROW PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER COMPLETE DOWN ARROW

Please print or type

Table with 4 columns: Date of Examination, Patient's Name, Date of Birth, Driver License ID

1) Have you conducted a physical examination of this patient? [] Yes [] No

If "Yes", please describe: _____

2) Does the patient receive any medication? [] Yes [] No

If "Yes", please specify the type and dosage: _____

3) Has the patient suffered any loss of body control, awareness or consciousness? [] Yes [] No

If "Yes", please complete DMV form MV-80U.1 (Physician's Statement for Medical Review Unit).

4) In your medical opinion, will the medical condition of the patient or the medication the patient takes prevent the safe operation of a motor vehicle? [] Yes [] No

If "No", do you recommend that DMV conduct an on-the-road driving performance evaluation?

[] Yes, please explain _____

[] No _____

*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, such as a cardiologist or a neurologist.

Table for signature and contact information: Signature of Physician/Physician Assistant/Nurse Practitioner, Specialty, License Number, Telephone Number, Address, State

