



To Our Driver License Customer:

The Department of Motor Vehicles has been notified that you have had, or are currently receiving treatment for, a medical condition that may impair your ability to safely operate a motor vehicle. We need more information about this condition.

Please have your healthcare provider (physician, physician assistant, or nurse practitioner) complete and sign this form. IMPORTANT: The information provided on this form must be based on an examination of you that was performed by your health care provider within the last six months. Bring the completed, signed form and a sample of your health care provider's stationery or voided blank prescription to any Motor Vehicle office.

For re-examination, please bring this form on the date of your scheduled appointment.

Please be assured that all medical information we receive will be treated as strictly personal and confidential.

Thank you for your help.
Department of Motor Vehicles

Please print or type

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

Have you treated this patient? Yes No

If "Yes", please describe the condition you treated or are treating:

Is the patient receiving medication for this condition? Yes No

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

Has the patient suffered any loss of body control, awareness or consciousness due to this condition? Yes No

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

In your opinion, would this patient's condition, or the medication he/she is taking, interfere with his/her ability to safely operate a motor vehicle?

Yes - permanently Yes - temporarily No

If "No", do you recommend the Department 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; ex: cardiologist; neurologist.

DOCTOR – please give your patient a sample of your stationery (showing your letterhead), or a voided prescription blank, as additional verification for this statement.

Table with 4 columns: Signature of Physician/Physician Assistant/Nurse Practitioner, Specialty, License Number, Telephone Number, Address, State

