NEW YORK STATE | Department of Motor Vehicles

PHYSICIAN'S STATEMENT

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

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.

Signature of Physician/Physician Assistant/Nurse Practitioner	Specialty	License Number
➧		

Telephone Number	Address	State
( )		