To Our Driver License Customer:

Use this form to report medical, physical, mental or a combination of such conditions to the Medical Review Unit.

Please complete the information below and have your physician/physician assistant/nurse practitioner complete the statement on **Page 2**.

**IMPORTANT:** The information provided must be based on a current examination performed by your physician/physician assistant/nurse practitioner within the last 120 days from the date this statement is submitted.

**NOTE:** Information provided by emergency care personnel is NOT acceptable. After review of the completed statement you may be requested to provide additional information from either the physician/physician assistant/nurse practitioner who provided the information or from a qualified specialist.

### PLEASE PRINT OR TYPE

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Date of Birth (Month/Day/Year)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
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<td>/ /</td>
<td>Male</td>
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<td>Female</td>
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</tbody>
</table>

Mailing Address (Number and Street)

City

State

Zip Code

Client ID No. (Driver License No.)

Any other names that you have used *(if applicable)*

Daytime Telephone Number *(Area Code)*

( )

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I am being treated and/or have been treated for the following medical, physical, or mental condition(s):

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

Please check the appropriate box(es) below and fill in your physician/physician assistant/nurse practitioner’s name:

- [ ] I am being treated primarily by my primary care physician, Dr. ________________________________.
- [ ] I am being treated primarily by my nurse practitioner, N.P. ________________________________.
- [ ] I am being treated primarily by my physician assistant, P.A. ________________________________.
- [ ] I am being treated by my specialist, Dr. ________________________________.
- [ ] I am being treated by my psychiatrist/psychologist, Dr. ________________________________.

Please have your physician/physician assistant/nurse practitioner complete page 2, and then return this form to:

Medical Review Unit
Driver Improvement Bureau
NYS Department of Motor Vehicles
6 Empire State Plaza
Albany, NY 12228
(518) 474-0774

Visit us at: dmv.ny.gov
1. Examination Date (must be within 120 days from the date this form is submitted): __________ / __________ / __________

2. Condition patient is being treated for:
   - [ ] Epilepsy/convulsive disorder
   - [ ] Syncope/fainting/dizziness or a condition that causes unconsciousness
   - [ ] Diabetes
   - [ ] Sleep disorder
   - [ ] Head trauma/tumor
   - [ ] Heart condition
   - [ ] Diabetes
   - [ ] Sleep disorder
   - [ ] Head trauma/tumor
   - [ ] Heart condition
   - [ ] Dementia/senility/Alzheimer’s a condition that causes unconsciousness
   - [ ] Stroke
   - [ ] Neurological or neuromuscular disease
   - [ ] Mental disorder
   - [ ] Other (please specify) ____________________________________________________________

3. Symptoms, severity, and frequency of condition:
   ____________________________________________________________________________________
   ____________________________________________________________________________________

4. Date of the last episode/incident associated with this condition: ____________________________

5. Have any episode(s)/incident(s) associated with this condition caused any loss of consciousness, awareness, and/or body control?
   - [ ] YES  [ ] NO
   If YES, list the dates of the episode(s)/incident(s) __________________________________________
   ____________________________________________________________________________________

6. Give a brief description regarding any factors that may have caused/contributed to the episode(s)/incident(s):
   ____________________________________________________________________________________
   ____________________________________________________________________________________

7. To the best of your knowledge have any of the patient’s episode(s)/incident(s) resulted in a motor vehicle accident(s) and/or incident(s)?
   - [ ] YES  [ ] NO
   If YES, please give details and the dates of the episode(s)/incident(s) and related accident(s): ____________________________________________________________________________________

8. Tests conducted (e.g., EEG, EKG, MRI, sleep study, serum levels, etc.): ______________________

9. Current treatment, medication and dosage, and /or therapy:
   ____________________________________________________________________________________
   ____________________________________________________________________________________

The following MUST be answered if the patient has a sleep disorder:

a.) Date first diagnosed with the sleep disorder: _____________________________________________

b.) Is patient receiving treatment? _______ Type of treatment __________________________ Date treatment began: __________

c.) Is patient compliant with the treatment? ________________________________________________

10. In my medical opinion, at this time (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.
   - [ ] the patient’s condition will not interfere with the safe operation of a motor vehicle.
   Please provide further detail in the space provided or in an attached statement on your letterhead:
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

Physician/Physician Assistant/Nurse Practitioner’s Name (Please print in full)
__________________________________________________________

Certificate or license number and state where licensed
__________________________________________________________

Physician/Physician Assistant/Nurse Practitioner’s Mailing Address (include number and street)
__________________________________________________________

Telephone Number (area code) __________________________

City __________________________ State __________________________ Zip Code __________________________

[ ] Primary care physician  [ ] Neurologist  [ ] Psychiatrist/Psychologist
[ ] Physician/Physician Assistant/Nurse Practitioner  [ ] Endocrinologist  [ ] Other

Physician/Physician Assistant/Nurse Practitioner’s Signature __________________________
__________________________________________________________________________________

Date (Month/Day/Year) __________ / __________ / __________

(Information provided by emergency care personnel is NOT acceptable.)