

MEDICAL EXAMINATION REPORT FORMS

Driver Name (first, middle, last, suffix)	Date of Birth	Customer Number	State	Phone ()
Street Address	City	State	Zip	
Symptoms and/or Medical Conditions Reported to MVD (Information reported to MVD is confidential and not subject to release)				

MUST BE COMPLETED BY PATIENT

Medical Information Release – I hereby authorize this physician to release to the Motor Vehicle Division any requested medical information that is pertinent to my ability to safely operate a motor vehicle.

Patient Name (or legal guardian)	Signature	Date
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MUST BE COMPLETED BY PHYSICIAN – Examination Date must be within 90 days of the date received by MVD to be accepted.

Examination Date	Diagnosis
Symptoms	
Are the symptoms present at all times? ☐ Yes ☐ No	Do you recommend that MVD monitor this person's condition by requiring periodic medical reviews? ☐ Yes (how often?); ☐ No
Current Medications	
Do you recommend continuation of driving privilege? ☐ Yes ☐ No (please explain)	
Do you recommend any of the following tests? ☐ None ☐ Written ☐ Road/Driving	

Complete ONLY for persons with episodes of "altered consciousness".

Date of Most Recent Episode	Describe Type of Episode
Aftereffects of Episodes (i.e., those which could result in fatigue, disorientation or short term inability to function)	
Are episodes under control? ☐ Yes ☐ No (please explain)	Does this person require medication for episodes? ☐ Yes ☐ No
Is this person compliant with required medical treatment? ☐ Yes ☐ No (please explain)	
The most recent episode: ☐ Was due to deliberate change in anticonvulsant medication ordered by physician. Episode control has since been established with reasonable medical certainty. ☐ Was an isolated occurrence. Another episode is unlikely to occur with reasonable medical certainty. ☐ Occurred only during sleep. ☐ Seizures have an established pattern of an aura of sufficient duration to allow an individual to safely cease operating a motor vehicle upon onset of the aura.	

Physician Name (printed)	Physician Signature			
Medical License Number	☐ MD ☐ DO	State	Phone ()	
Street Address	City	State	Zip	