



**PHYSICIAN'S STATEMENT**

To Our Driver License Customer:

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.

More information from your doctor about this condition is required. Please have your doctor fill out the statement below. **IMPORTANT:** The information provided in the statement must be based on an examination of you that this doctor performed within the last six months.

After the doctor completes the statement, please bring the statement and a sample of the doctor's stationery (or a voided prescription blank from the doctor's office) to any Motor Vehicles office.

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

Please be assured that all medical information we receive from you and your doctor 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	CID	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

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

Physician's Signature	Specialty	License Number
Telephone Number ( )	Address	State

