



INSTRUCTIONS:

- Please provide all of the information requested in **Parts 1 through 3** below, and sign and date the form.
- This form is provided for use by a physician, physician assistant, or nurse practitioner to report an individual whose driving ability may be affected due to some physical or mental impairment.
- This form must be completed and signed by a licensed physician, physician assistant or nurse practitioner.
- If additional assistance is needed, please contact the Medical Review Unit at (518) 474-0774, option #2 then option #3.
- If your patient is an older driver, you may also visit the Resources for the Older Driver website at dmv.ny.gov/olderdriver.
- Mail the completed form to: Medical Review Unit, NYS Department of Motor Vehicles, 6 Empire State Plaza, Room 337, Albany, NY 12228

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, such as a cardiologist or neurologist.

PART 1 - DRIVER IDENTIFICATION (please print)

* Required information

Driver License Number

Last Name*	First Name*	M.I.	Date of Birth (if not known, give approximate age)	
Street Address				
City*			State	Zip Code

PART 2 - DESCRIPTION OF THE DRIVER'S CONDITION

Have you treated this patient? YES NO

If Yes: Date of Last Examination? _____

Please describe the condition that you have treated or are currently treating:

Is the patient receiving medication for this condition? YES NO

If Yes: Please specify the type and dosage:

In my medical opinion, (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.

Please provide further detail in the space provided or in an attached statement on your letterhead:

PART 3 - IDENTIFICATION AND CERTIFICATION OF THE PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER COMPLETING THIS REPORT

Your name (Print name in full)	Certificate or Lic. No.	Specialty (Please specify)		
Your Mailing Address (Include Street & No.)				State Where Licensed
City	State	Zip Code	(Area Code) & Telephone Number ()	
Your Signature (Sign name in full) X				Date (Month/Day/Year) / /