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.

<table>
<thead>
<tr>
<th>PLEASE PRINT OR TYPE</th>
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<tbody>
<tr>
<td>Last Name</td>
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<tr>
<td>First Name</td>
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<tr>
<td>M.I.</td>
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<tr>
<td>Date of Birth (Month/Day/Year)</td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<tr>
<td>Mailing Address (Number and Street)</td>
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<tr>
<td>City</td>
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<tr>
<td>State</td>
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<tr>
<td>Zip Code</td>
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<tr>
<td>Client ID No. (Driver License No.)</td>
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<td>Any other names that you have used (if applicable)</td>
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<td>Daytime Telephone Number (Area Code)</td>
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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:  www.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
   - Dementia/senility/Alzheimer’s
   - Head trauma/tumor
   - Heart condition
   - 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:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Patient’s Last Name First Name M.I. Date of Birth (Month/Day/Year)  
[ ] Male  [ ] Female

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

City State Zip Code

Physician/Physician Assistant/Nurse Practitioner’s Signature

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

Date (Month/Day/Year) /

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