DS-6 (12/12)

New York State Department of Motor Vehicles

PHYSICIAN'S REPORTING FORM

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 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 or nurse practitioner.
- Attach a sheet of your stationery (showing your letterhead), or a voided or blank prescription form, as additional verification for this statement, and mail the completed form with the attached stationery or prescription to: Medical Review Unit, New York State Department of Motor Vehicles, 6 Empire State Plaza, Room 337, Albany, NY 12228.
- If additional assistance is needed, please contact the Medical Review Unit at (518) 474-0774, option #3. Hours are 8:30 am to 12:00 pm.
- If your patient is an older driver, you may also visit the Resources for the Older Driver website at www.dmv.ny.gov/olderdriver.

PART 1 - DRIVER IDENTIFICATION *(please print)*

Last Name*	First Name*	M.I.	Date of Birth (if not known, give approximate age)	
Street Address				
City*			State	Zip Code
Make of Vehicle the Person Normally Drives	Color of Vehicle		License Plate Number	

* *Required information*

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 MAKING 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*) ➧			Date (*Month/Day/Year*) / /