



**PHYSICIAN'S STATEMENT FOR MEDICAL REVIEW UNIT**

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/nurse practitioner complete the statement on **Page 2**.

**IMPORTANT: The information provided must be based on a current examination performed by your physician/nurse practitioner within the last 120 days from the date this statement is submitted.**

**NOTE: Information provided by a physician assistant or emergency care personnel is NOT acceptable. After review of the completed statement you may be requested to provide additional information from either the physician/nurse practitioner who provided the information or from a qualified specialist.**

**PLEASE PRINT OR TYPE**

Last Name	First Name	M.I.	Date of Birth (Month/Day/Year) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Number and Street)				
City		State	Zip Code	
Client ID No. (Driver License No.)	Any other names that you have used (if applicable)	Daytime Telephone Number (Area Code) ( )		

I am being treated and/or have been treated for the following medical, physical, or mental condition(s):

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Please check the appropriate box(es) below and fill in your physician/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 by my specialist, Dr. \_\_\_\_\_.
- I am being treated by my psychiatrist/psychologist, Dr. \_\_\_\_\_.

**Please have your physician/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



**THIS SIDE IS TO BE COMPLETED BY YOUR PHYSICIAN/NURSE PRACTITIONER**

**Physician/Nurse Practitioner: Please attach a sample of your letterhead or a voided prescription blank.**

**PLEASE PRINT OR TYPE**

Patient's Last Name	First Name	M.I.	Date of Birth (Month/Day/Year) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
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1. Examination Date (must be **within 120 days** from the date this form is submitted): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
2. Condition patient is being treated for:
 

<input type="checkbox"/> Epilepsy/convulsive disorder	<input type="checkbox"/> Syncope/fainting/dizziness or	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sleep disorder
<input type="checkbox"/> Dementia/senility/Alzheimer's	<input type="checkbox"/> a condition that causes unconsciousness	<input type="checkbox"/> Head trauma/tumor	<input type="checkbox"/> Heart condition
<input type="checkbox"/> Stroke	<input type="checkbox"/> Neurological or neuromuscular disease	<input type="checkbox"/> Mental disorder	
<input type="checkbox"/> 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 your medical opinion, at this time, would the patient's condition interfere with the safe operation of a motor vehicle?**

YES  NO (If YES, please explain in the space provided or in an attached statement on your letterhead.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE: If you answered YES to question 10, skip Question 11.**

11. Do you recommend the Department conduct an on-the-road driving performance evaluation?  YES  NO

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

Physician/Nurse Practitioner's Name (Please print in full)			Certificate or license number and state where licensed		
Physician/Nurse Practitioner's Mailing Address (include number and street)				Telephone Number (area code) ( )	
City	State	Zip Code	<input type="checkbox"/> Primary care physician <input type="checkbox"/> Neurologist <input type="checkbox"/> Psychiatrist/Psychologist <input type="checkbox"/> Physician/Nurse Practitioner <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Other _____		
Physician/Nurse Practitioner's Signature					Date (Month/Day/Year) / /

**(Information provided by a physician assistant or emergency care personnel is NOT acceptable.)**