OFFICE OF THE SECRETARY OF STATE
DRIVER SERVICES DEPARTMENT

DRIVER ANALYSIS DIVISION
2701 S. DIRKSEN PARKWAY
SPRINGFIELD, IL 62723
217-782-7246
www.cyberdriveillinois.com

Medical Report

Please see guidelines at www.cyberdriveillinois.com, search for Medical/Vision Conditions for completion of form.

SECTION I — To be completed by driver. (Please print or type.)

Name: _____ Driver's License Number: _____
Last First Middle

Street Address: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female
Month Day Year

City: _____ ZIP Code: _____

Agreement/Release of Information

I agree to remain under the care of my physician and follow the treatment exactly as prescribed. I hereby authorize and request my physician to release information regarding my medical condition to the Illinois Secretary of State, and to report any change in the status of my condition that would impair my ability to safely operate a motor vehicle. I understand that failure to abide by the conditions set forth in this agreement are grounds for the Secretary of State to deny or cancel my driving privileges. ***This report shall remain valid for three months (90 days).***

_____ _____
Signature of Individual Date of Signature

SECTION II MEDICAL HEALTH — To be completed by MD/DO and/or medical professional (NP/PA).

DATE OF COMPLETION OF MEDICAL HEALTH SECTION II: _____

1. **Required: In your professional opinion, is this individual MEDICALLY FIT to safely operate a motor vehicle?** **YES** ☐ **NO** ☐

2. Conditions: Yes or No required for each condition listed.
   - (a) Cardiovascular YES ☐ NO ☐ (provide condition)_____
   - (b) Neurological YES ☐ NO ☐ (provide condition)_____
   - (c) Musculoskeletal YES ☐ NO ☐ (provide condition)_____
   - (d) Respiratory YES ☐ NO ☐ (provide condition)_____
   - (e) Seizure YES ☐ NO ☐ (provide condition)_____
   - (f) Diabetes YES ☐ NO ☐
   - (g) Dizzy/Fainting Spell YES ☐ NO ☐
   - (h) Alcohol/Drug Abuse YES ☐ NO ☐
   - (i) Other Medical Condition(s) (provide condition)_____

   ***For mental health disorders, please refer to Section III-Mental Health.**

3. **List all current medications. (If medications are listed, a condition must be disclosed above in Question #2.)** _____

4. ☐ No medications prescribed.

5. **Required:** Current Status of Condition:
   (A) Controlled ☐ (B) Not Controlled: **will not affect driving** ☐ (C) Not Controlled: **may affect driving** ☐
   (If Not Controlled is marked, you must provide details, which may include pertinent clinical information, i.e., test results, lab values.)

(continued on back)

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PATIENT'S NAME: _____

6. **Required:** In the past six months, has the driver's ability to safely operate a motor vehicle been impaired (due to any reason) or has driver experienced an attack of unconsciousness? YES ☐ NO ☐ Date of Attack: _____

   (If YES, you must provide details, which may include pertinent clinical information.)

   _____

   _____

7. Date of last impaired ability to safely operate a motor vehicle or attack of unconsciousness. Date: _____
   (You must provide details, which may include pertinent clinical information.)

   _____

   _____

SECTION III MENTAL HEALTH — To be completed ONLY if driver has a Mental Health Disorder marked "YES" by MD/DO and/or medical professional (NP/PA).

Mental Health Disorder: YES ☐ NO ☐

DATE OF COMPLETION OF MENTAL HEALTH SECTION III: _____

1. **Required: In your professional opinion, is this individual MENTALLY FIT to safely operate a motor vehicle?** **YES ☐ NO ☐**
2. Mental Health Disorder Diagnosis/Condition(s): _____
3. **List all current mental health medications. (If medications are listed, a condition must be disclosed above in Question #2.)**

   _____

   _____

4. ☐ No medications prescribed.
5. (A) Controlled ☐ (B) Not Controlled: **will not affect driving** ☐ (C) Not Controlled: **may affect driving** ☐
   (If Not Controlled is marked, you must provide details, which may include pertinent clinical information, i.e., test results, lab values.)

   _____

SECTION IV — Additional information, special restrictions, etc.

_____

_____

_____

SECTION V — MD/DO and/or medical professional (NP/PA) — Failure to provide license information will result in return of form to the driver.

(Unacceptable Signatures: Chiropractors, Podiatrists, Residents, Fellows, Interns, RN's, LPN's, Co-signatures)

MEDICAL:

_____ Provider Name (**PRINTED**)

_____ Professional License Number/State License Issued

_____ Provider's **SIGNATURE** — Date of Completion

_____ Medical Provider's Address (**PRINTED/STAMPED**)

( ) _____ Telephone Number

☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** Provider's Specialty

MENTAL:

_____ Provider Name (**PRINTED**)

_____ Professional License Number/State License Issued

_____ Provider's **SIGNATURE** — Date of Completion

_____ Medical Provider's Address (**PRINTED/STAMPED**)

( ) _____ Telephone Number

☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** Provider's Specialty

PLEASE MAINTAIN A COPY FOR YOUR RECORDS.