



**PHYSICIAN'S REQUEST FOR DRIVER REVIEW**

**INSTRUCTIONS:**

- Please provide all of the information requested in **Parts 1 through 3** below, and sign and date the form.
- When reporting an individual whose driving ability is questionable due to some physical or mental impairment, please provide as much detail as possible.
- This form must be completed and signed by a licensed physician.
- 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: Driver Improvement Bureau, New York State Department of Motor Vehicles, 6 Empire State Plaza, Albany, NY 12228.

**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 you treated or are treating:

Is the patient receiving medication for this condition?  YES  NO

If Yes: Please specify the type and dosage:

In your medical opinion, 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:** An on-the-road driving evaluation CANNOT be conducted if you check the YES box above. To request this evaluation, check the box below and provide the reason.

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

If Yes: Please explain 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) / /