



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):

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	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 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:

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.)