State of Maine
Department of the Secretary of State

Bureau of Motor Vehicles

DRIVER MEDICAL EVALUATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ LICENSE/HISTORY NUMBER: _____

_____ PRINT DATE: _____

TELEPHONE #: _____

(Please Enter Phone Number)

CERTIFICATE OF EXAMINATION

FOR THE REPORTING PHYSICIAN:

1. This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition which could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office.

2. A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A MRSA Section 1258 (6).

FUNCTIONAL ABILITY PROFILE

Please complete the profile level for the listed conditions and provide information for any other conditions not listed below that may affect the driver's ability to drive a motor vehicle safely.

DIAGNOSIS
(PLEASE PRINT OR TYPE)
If COPD Profile Level B or C provide 0_2 Sats _____.

_____

_____

_____

PROFILE LEVEL
THIS SECTION MUST BE COMPLETED
CHECK ONLY ONE BOX PER DIAGNOSIS

	1.	2.	3. A	3. B	3. C	3. D	4.
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Date of last examination _____ How long has applicant been your patient? _____
(must be within past year)

For seizures/stroke or loss of consciousness give date of most recent episode_____

Current prescribed medication(s): _____

_____

☐ No medication prescribed

Reliability in taking medication
Good ☐ Fair ☐ Poor ☐ Unknown ☐

Has this patient demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle?

_____

_____

* A copy of the rules can be viewed at www.maine.gov/sos/bmv/licenses/medical or a Functional Ability Profile booklet can be obtained by calling (207) 624-9000 extension 52124

PHYSICIAN'S COMMENTS

(Important - please describe physical and/or cognitive deficits.)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical history to the Secretary of State, Bureau of Motor Vehicles and understand the information may be shared with any qualified medical professional submitting information pertaining to the disclosed medical history for the purpose of determining my eligibility for a driver's license by:

Dr. _____or_____Hospital

Signature of Patient: _____Date_____
(Please forward this form directly to your physician for completion)

Patient Telephone number: _____

Being duly licensed to practice in the state of _____I hereby certify that I have examined this applicant.

_____ _____
(Signature) (Specialty)

_____ _____
(Physician's Name Printed or Typed) (Address)

_____ _____
(Office Phone Number) (Date)

Reply to: Medical Review Coordinator
Bureau of Motor Vehicles
29 State House Station
Augusta, Maine 04333-0029
Telephone: (207) 624-9000, ext 52124
Fax: (207) 624-9319

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