GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLES

MEDICAL/EYE REPORT

You may mail this form to DC Department of Motor Vehicles, PO Box 90120, Washington, DC 20090 or fax it to (202) 673-9908.
Visit our website: www.dmv.dc.gov or call 311 or 202-737-4404 for additional information.

This section must be completed by the customer.

LAST NAME	FIRST NAME	MIDDLE NAME		
ADDRESS	**APT/UNIT #**	**CITY**	**STATE**	**ZIP CODE**
		WASHINGTON	DC	
DATE OF BIRTH *(MM/DD/YYYY)*	**DRIVER LICENSE NUMBER**	**TELEPHONE NUMBER**	**E-MAIL ADDRESS**	

MEDICAL REPORT: This section must be completed by a licensed physician.

Alzheimer	*Insulin Dependent Diabetic	Seizure or Fainting Spells	Other Mental or Physical Conditions
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

*Medical Report section must be completed by physician **and** Eye Report section must be completed by Ophthalmologist or Optometrist

Seizure or fainting spells If yes, when was the last episode? _____ **NOTE:** Must be seizure free for twelve (12) consecutive months, unless single episode, night time only seizures or due to medication adjustments.	If applicant has a mental or physical condition that would impair his/her ability to drive, please indicate condition:
Indicate any medical restrictions required:	

Indicate by checking one (1) of the following when the condition should be rechecked by a physician.
Seizure disorders require a one year physician examination for five (5) consecutive years

❑ Six (6) months	❑ One (1) year	❑ Two (2) years	❑ Three (3) years	❑ Four (4) years

Based on your medical diagnosis, does the applicant have the ability to safely operate a motor vehicle? Yes ❑ No ❑

Physician Information:

Physician License Identification Number and State:_____ Telephone No:_____

Physician Address: _____

Physician Signature:_____Date:_____

EYE REPORT: This section must be completed by a licensed Ophthalmologist or Optometrist.

*Insulin Dependent Diabetic	Glaucoma	Cataracts	❑ Other Eye Disease:	Failed DMV Vision Test
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	_____	❑ Yes ❑ No

Vision without Glasses	Vision with Glasses	Field of Vision in horizontal meridian	Indicate by checking one (1) of the following when the condition should be rechecked.
Right Eye 20/_____ Left Eye 20/_____ Both Eyes 20/_____	Right Eye 20/_____ Left Eye 20/_____ Both Eyes 20/_____		❑ Six (6) months ❑ Three (3) years ❑One (1) year ❑ Four (4) years ❑Two (2) years
Minimum Vision Requirements (with or without corrective lenses): No less than 20/40 in the best eye OR no less than 20/70 in the best eye and field of vision at least 140 degrees.			Indicate any vision restrictions required:

Based on your medical diagnosis, does the applicant have the ability to safely operate a motor vehicle? Yes ❑ No ❑

Ophthalmologist or Optometrist Information:

Physician License Identification Number and State:_____ Telephone No: _____

Physician Address: _____

Physician Signature:_____Date:_____

The making of a false statement on this form is a violation of DC law and subject to a fine of up to $1,000 or 180 days imprisonment of both. (D.C. Official Code §22-2405)
To report waste, fraud, or abuse by any DC Government Agency or official, call the Office of the DC Inspector General at 1-800-521-1639.