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Carson City, NV 89711
Reno/Sparks/Carson City (775) 684-4DMV (4368)
Las Vegas Area (702) 486-4DMV (4368)
Rural Nevada or Outside Nevada (877) 368-7828
Fax: (775) 684-4829
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CONFIDENTIAL PHYSICIAN'S REPORT

PLEASE NOTE: According to the Nevada Administrative Code 483.310, the Department of Motor Vehicles MUST receive this report within 30 DAYS after the date of the examination. All questions must be answered.

Driver's License No. _____ Date of Birth (MM/DD/YYYY) _____

Patient's Name _____
Last First Middle

1. Diagnosis: _____

2. **In your opinion, will this medical condition affect the patient's ability to drive a vehicle safely?**
☐ Yes* ☐ No ☐ Uncertain* ***If Yes or Uncertain, please explain:***

3. Status of Patient's Medical Condition(s)*:
☐ Improving ☐ Stable ☐ Worsening or Deteriorating ☐ Subject to Change
**If multiple conditions exist, please describe status and prognosis.*

4. How long has this person been your patient?
_____ Years _____ Months Date of Last Examination: _____

5. Is your patient under a controlled medical program? ☐ Yes* ☐ No
If **Yes, how long has control been maintained?* _____ Years _____ Months

6. Is the patient adhering to the medical regimen? ☐ Yes ☐ No*
If **No, please explain:*

7. Is the patient knowledgeable about the medical condition? ☐ Yes ☐ No

8. Medications prescribed (please list **type** and **dosage**):

9. **Will these medications affect the patient's ability to operate a motor vehicle safely?**
☐ Yes* ☐ No **If **Yes**, please explain:*

Please complete BOTH SIDES of this form.

10. Does the nature of the condition indicate loss/lapse of consciousness, seizure activity, fainting or dizzy spells? ☐ Yes* ☐ No

***If Yes, please indicate the date** (MM/DD/YYYY) **of the last occurrence:** _____

10a. Was the seizure or loss of consciousness an isolated incident? ☐ Yes ☐ No

10b. Are additional seizures likely to occur? ☐ Yes ☐ No

11. Please recommend any restrictions you feel are necessary for this patient to safely drive a vehicle:

_____

_____

_____

_____

_____

12. Physician's Comments:

_____

_____

Date of Examination	Signature of Attending Physician Physician Number
Physician's Office Phone Number	Please PRINT Name of Physician
Office Address of Physician City	State and Zip Code

I hereby authorize any physician, surgeon, medical practitioner or other person, and/or any clinic, or hospital, including the Department of Veterans Affairs or government hospital, to release any and all acquired medical information that specifically addresses the information on this form and may relate to, or affect my ability to operate a motor vehicle safely.

_____ _____

Patient's Signature Date

You have the option of having an indicator of a medical condition imprinted on your driver's license or identification card to alert police and medical personnel. Your physician must state on this form that you suffer from any of the medical conditions listed below.

- ☐ 250.3 Diabetes with other coma
- ☐ 345.9 Epilepsy
- ☐ 369.00 Blindness and low vision
- ☐ 389.1 Deafness
- ☐ 414.0 Coronary Atherosclerosis
- ☐ 496.0 Chronic Airway Obstruction
- ☐ E934.2 Anticoagulants (adverse effect)
- ☐ 995.6 Food Allergies
- ☐ 995.86 Malignant Hyperthermia
- ☐ 719.7 Difficulty in walking

You must present this form in person to the DMV if you wish to have one of these medical conditions imprinted on your driver's license or identification. If mailed, your medical indicator cannot be processed. There is a $3 fee to have this added.

PLEASE NOTE:
According to the *Nevada Administrative Code*, the Department of Motor Vehicles **MUST** receive this report within **30 DAYS** after the date of the examination.