A Public Service Agency

DRIVER MEDICAL EVALUATION

(Medical information is CONFIDENTIAL under *California Vehicle Code* §1808.5 CVC)

INSTRUCTIONS TO THE DRIVER: Please take this form to the medical professional most familiar with your health history and current medical condition. Before giving this form to your medical professional, complete and sign Sections 1-3. **PLEASE PRINT LEGIBLY.**

INSTRUCTIONS TO THE MEDICAL PROFESSIONAL: Please complete Sections 5-13, on pages 2 through 5. The Department of Motor Vehicles (DMV) records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. In this case, the department is concerned about the following condition:

RETURN BY:

PHYSICIAN RETURN FORM TO:

FAX NUMBER:

SECTION 1 — DRIVER INFORMATION

NAME (LAST, FIRST, MIDDLE)	DRIVER LICENSE NO.	BIRTH DATE	FIELD FILE

STREET ADDRESS	CITY	ZIP	PATIENT'S DAYTIME OR HOME PHONE NO.

DRIVER MUST COMPLETE HEALTH HISTORY BELOW. (Please explain any "YES" answers)

YES	NO		YES	NO	
		Head, neck, spinal injury, disorders or illnesses			Kidney disease, stones, blood in urine, or dialysis
		Seizure, convulsions, or epilepsy			Muscular disease
		Dizziness, fainting, or frequent headaches			Any permanent impairment
		Eye problem (except corrective lenses)			Nervous or psychiatric disorder
		Cardiovascular (heart or blood vessel) disease			Regular or frequent alcohol use
		Heart attack, stroke, or paralysis			Problems with the use of alcohol or drugs
		Lung disease (include tuberculosis, asthma or emphysema)			Other disorders or diseases
		Nervous stomach, ulcer, or digestive problems			Any major illness, injury, or operations in last 5 years
		Diabetes or high blood sugar			Currently taking medications

EXPLANATION: *(Include onset date, diagnosis, medication, doctor's name and address and any current condition or limitation. Attach additional sheet, if needed).*

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I further certify that all information concerning my health is true and correct.

DATE	DRIVER'S SIGNATURE
	X Sign Here

SECTION 2 — DRIVER'S ADVISORY STATEMENT

Medical information is required under the authority of Divisions 6 and 7 of the *California Vehicle Code* (CVC). Failure to provide the information is cause for refusal to issue a license or to withdraw the driving privilege.

All records of the DMV, relating to the physical or mental condition of any person, are confidential and not open to public inspection (CVC §1808.5). Information used in determining driving qualifications is available to you and/or your representative with your signed authorization.

The department has sole responsibility for any decision regarding your driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

SECTION 3 — MEDICAL INFORMATION AUTHORIZATION

MEDICAL PROFESSIONAL, HOSPITAL, OR MEDICAL FACILITY (NAME AND ADDRESS)

DATE	MEDICAL RECORD/PATIENT FILE NO.

I hereby authorize my medical professional or hospital to answer any questions from the DMV, or its employees, relating to my physical or mental condition, and/or drug and/or alcohol use, and to release any related information or records to the DMV or its employees. Any expense involved is to be charged to me and not to the DMV.

I hereby authorize the DMV to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

NOTE: You may wish to make a copy of the completed Driver Medical Evaluation for your records.

SIGNED	DATE
X Sign Here	

Print Clear Form