



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 doctor complete the statement on **Page 2**.

IMPORTANT: The information provided must be based on a current examination performed by your physician within the last 120 days from the date this statement is submitted. Information provided by an emergency care doctor, nurse practitioner or physician's assistant is NOT acceptable. After review of the completed statement you may be requested to provide additional information from either the physician 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 doctor's name:

- I am being treated primarily by my primary care physician, Dr. _____.
- I am being treated by my specialist, Dr. _____.
- I am being treated by my psychiatrist/psychologist, Dr. _____.

Please have your physician complete page 2, and then return this form to:

Department of Motor Vehicles
Driver Improvement Bureau
Medical Review Unit
6 Empire State Plaza, Room 220
Albany, NY 12228
(518) 474-0774

THIS SIDE IS TO BE COMPLETED BY YOUR PHYSICIAN

Physician: 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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- Examination Date (must be **within 120 days** from the date this form is submitted): _____ / _____ / _____
- Condition patient is being treated for:
 Epilepsy/convulsive disorder Syncope/fainting/dizziness or Diabetes Sleep disorder
 Dementia/senility/Alzheimer's a condition that causes unconsciousness Head trauma/tumor Heart condition
 Stroke Neurological or neuromuscular disease Mental disorder
 Other (please specify) _____
- Symptoms, severity, and frequency of condition: _____

- Date of the last episode/incident associated with this condition: _____
- 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) _____

- Give a brief description regarding any factors that may have caused/contributed to the episode(s)/incident(s): _____

- 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): _____

- Tests conducted (e.g., EEG, EKG, MRI, sleep study, serum levels, etc.): _____
- Current treatment, medication and dosage, and /or therapy: _____

The following **MUST** be answered if the patient has a **sleep disorder**:

- Date first diagnosed with the sleep disorder: _____
- Is patient receiving treatment? _____ Type of treatment _____ Date treatment began: _____
- Is patient compliant with the treatment? _____

10. In your medical opinion, at this time, would the patient's condition interfere with the safe operation of a motor vehicle?

YES NO (If YES, please explain in the space provided or in an attached statement on your letterhead.)

NOTE: If you answered YES to question 10, skip Question 11.

11. Do you recommend the Department conduct an on-the-road driving performance evaluation? YES NO

If YES, please explain: _____

Physician's Name (Please print in full)			Certificate or license number and state where licensed	
Physician'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"/> Endocrinologist <input type="checkbox"/> Other _____	
Physician's Signature ➔			Date (Month/Day/Year) / /	

(Information provided by an emergency care doctor, nurse practitioner or physician's assistant is NOT acceptable.)