HOSPITAL ER PHYSICIAN'S IMPAIRED DRIVER REPORT
P-142ER Rev. 11-2017

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
DRIVER SERVICES DIVISION
On The Web At: ct.gov/dmv

DRIVER'S LICENSE NUMBER

CDL/PS ☐ YES ☐ NO

MAIL TO: DMV, Driver Services Division, 60 State Street, Wethersfield, CT 06161-1013

INSTRUCTIONS: Under the provisions of Section 14-46 of the Connecticut General Statutes, any physician may report to the DMV, in writing, the name, age and address of any person diagnosed by him to have any chronic health problem which in the physician's judgment will significantly affect the person's ability to safely operate a motor vehicle, or to have recurrent periods of unconsciousness uncontrolled by medical treatment. Such reports shall be for the information of the commissioner in enforcing state motor vehicle laws, and used solely for the purpose of determining the eligibility of any person to operate a motor vehicle on the highways of this state.

PATIENT'S NAME: *(Please Print or Type)* *(Last)* *(First)* *(Initial)*	**DATE OF BIRTH:**
PATIENT'S ADDRESS:	**DATE OF EXAMINATION:**

TYPE OF IMPAIRMENT:

☐ Alcohol/Substance Abuse _____
☐ Alzheimer's/Dementia _____
☐ Cardiovascular/Hypertension _____
☐ Cerebral Palsy _____
☐ Cystic Fibrosis _____
☐ Endocrine/Glandular _____
☐ Liver/Renal Failure _____
☐ Neurological/Neuromuscular _____
☐ Ophthalmologic _____
☐ Orthopedic _____
☐ Peripheral Vascular Disease _____
☐ Psychiatric/Emotional Disorder _____
☐ Pulmonary/Sleep Apnea _____
☐ Spina Bifida _____
☐ Traumatic Brain Injury _____
☐ Other _____

☐ OTHER IMPAIRMENT OR MEDICAL CONDITION:

PHYSICIAN'S COMMENTS:

PHYSICIAN'S CERTIFICATION: I certify that I have personally examined the above named person within the 90 days preceding completion of this report. I swear or affirm under penalty of false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, and subject to penalties for perjury for a deliberate false statement, that the above information and any attachment hereto is true and correct.

PHYSICIAN'S NAME: *(Please print or type)*	**NAME OF HOSPITAL:**	**TELEPHONE NUMBER:**	**DATE OF REPORT:**
PHYSICIAN'S SIGNATURE:	**PHYSICIAN'S SPECIALTY:**	**PHYSICIAN'S LICENSE NUMBER:**	**STATE OF ISSUE:**