



OFFICE OF THE SECRETARY OF STATE
DRIVER SERVICES DEPARTMENT

DRIVER ANALYSIS DIVISION
2701 S. DIRKSEN PARKWAY
SPRINGFIELD, IL 62723
217-782-7246
ILSOS.GOV

Medical Report For Conditions That May Impair Driving Safely

Please see guidelines at ilsos.gov, search for Medical/Vision Conditions for completion of form.

SECTION I — To be completed by driver. (Please print or type.)

Name: _____ Driver's License Number: _____
Last First Middle

Street Address: _____ Date of Birth: _____ Gender: Male Female
Month Day Year

City: _____ ZIP : _____ Ph: (_____) _____

Agreement/Release of Information

*I agree to remain under the care of my physician and follow the treatment exactly as prescribed. I hereby authorize and request my physician to release information regarding my medical condition to the Illinois Secretary of State, and to report any change in the status of my condition that would impair my ability to safely operate a motor vehicle. I understand that failure to abide by the conditions set forth in this agreement will be grounds for the Secretary of State to deny or cancel my driving privileges. **THIS REPORT IS VALID FOR THREE MONTHS (90 DAYS).***

Signature of Individual

Date of Signature

SECTION II MEDICAL HEALTH — To be completed by MD/DO and/or medical professional (NP/PA).

DATE OF COMPLETION OF MEDICAL HEALTH SECTION II: _____

1. **Required: In your professional opinion, is this individual MEDICALLY AND MENTALLY FIT to safely operate a motor vehicle?** YES NO

2. Conditions: Yes or No required for each condition listed.
- (a) Cardiovascular YES NO (provide condition) _____
(NA for Hypertension or Hyperlipidemia)
 - (b) Neurological YES NO (provide condition) _____
 - (c) Musculoskeletal YES NO (provide condition) _____
 - (d) Seizures YES NO (provide condition) _____
 - (e) Diabetes YES NO
 - (f) Dizzy/Fainting Spells YES NO
 - (g) Alcohol/Drug Abuse YES NO
 - (h) Developmental YES NO (provide condition) _____
 - (i) Mental YES NO (provide condition) _____
 - (j) Other Condition(s) YES NO (provide condition) _____

3. (a) **LIST ALL current medications and dosages (including medications prescribed by another physician). If medications are listed, a condition must be disclosed above (in Question #2).** _____

(b) Does the patient have side effects from any medication(s) that would impair driver's ability to safely operate a motor vehicle?
YES Explain _____ **NO**

(c) Is the driver compliant with medication and treatment regime? YES NO Explain _____

(d) No medications prescribed.

(continued on back)

PATIENT'S NAME: _____

4. **Required:** Current Status of Condition:
(A) Controlled (B) Not Controlled: **will not affect driving** (C) Not Controlled: **may affect driving**
(If **Not Controlled** is marked, you must provide details, which may include pertinent clinical information, i.e., test results, lab values.)

5. **Required:** In the past six months, has the driver's ability to safely operate a motor vehicle been impaired (due to any reason) or has driver experienced an attack of unconsciousness? YES NO Date of Attack: _____
(If **YES**, you must provide details, which may include pertinent clinical information.)

6. Date of last impaired ability to safely operate a motor vehicle or attack of unconsciousness. Date: _____
(You must provide details, which may include pertinent clinical information.)

SECTION III — PROVIDER

- How long have you been treating this driver? _____
- Is the driver being treated by any other providers? YES NO
- If Question 2 is YES, name of physician and contact information: _____

NOTE: If treated by another provider, a statement regarding medical and mental fitness to operate a motor vehicle, or a completed Medical Report is required by that provider.

SECTION IV — Additional information, special restrictions, etc.

SECTION V — MD/DO and/or medical professional (NP/PA) — Failure to provide license information will result in return of form to the driver.

(Unacceptable Signatures: Chiropractors, Podiatrists, Residents, Fellows, Interns, RN's, LPN's, Co-signatures)

MEDICAL:

Provider Name (**PRINTED**)

Medical Provider's Address (**PRINTED/STAMPED**)

Professional License Number/State License Issued

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Telephone Number

Provider's **SIGNATURE** — Date of Completion

MD **DO** **NP** **PA** Provider's Specialty

OTHER PROVIDER:

Provider Name (**PRINTED**)

Medical Provider's Address (**PRINTED/STAMPED**)

Professional License Number/State License Issued

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Telephone Number

Provider's **SIGNATURE** — Date of Completion

MD **DO** **NP** **PA** Provider's Specialty

PLEASE MAINTAIN A COPY FOR YOUR RECORDS.