MEDICAL REVIEW AFFIDAVIT

Mail: Kentucky Transportation Cabinet, Department of Vehicle Regulation, Medical Review Board Office
200 Mero Street, Frankfort, KY 40622,

Email: KYTC.MedicalReviewBoard@ky.gov Phone: (502) 564-1257 FAX: (844) 503-4111

This form may be used to report a driver with a physical or mental impairment. Pursuant to 601 KAR 13:090, unless you are a physician, law enforcement officer, KSP license examiner, Commonwealth or county attorney, county or circuit clerk, sheriff, relevant employee of a government agency, or judge, **this form must include notarized signatures of at least two (2) citizens** attesting that the driver is incapable of safely operating a motor vehicle due to a physical or mental condition. The Transportation Cabinet may be required to release this document upon request by the driver or his or her representative; therefore, this document cannot be kept confidential.

SECTION 1: DRIVER INFORMATION (*Please print or type.*)

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	
DRIVER'S LICENSE NO.	**SOCIAL SECURITY NO.** (*optional*)	**DATE OF BIRTH** (*mm/dd/yyyy*)	
ADDRESS (*street)*	**CITY**	**STATE**	**ZIP**

Explain in detail why you believe the driver is incapable of safely operating a motor vehicle. Please describe any unsafe driving behavior you have witnessed, any known physical or mental conditions that affect driving, and any incidents leading to this report. If more space is needed, please attach additional sheets.

(*If reporting a seizure, please provide the date of last known seizure*.)
Date of last known seizure (*mm/dd/yyyy*):

SECTION 2: REPORTING INDIVIDUAL(S) (*Please print or type.*)

Anonymous reports cannot be accepted. Please indicate whether you are a:

☐ KSP license examiner ☐ Commonwealth/county attorney ☐ Employee of government agency
☐ Law Enforcement Officer ☐ County clerk or circuit clerk ☐ Physician ☐ Judge ☐ Sheriff

If none of the above, two notarized signatures are required below.

LAST NAME	**FIRST NAME**	**MI**	**TITLE** (*if applicable*)	**PHONE NUMBER**
ADDRESS (*street*)	**CITY**		**STATE**	**ZIP**

LAST NAME	**FIRST NAME**	**MI**	**TITLE** (*if applicable*)	**PHONE NUMBER**
ADDRESS (*street*)	**CITY**		**STATE**	**ZIP**

SIGNATURE **DATE SIGNED** **SIGNATURE # 2** (*required if a citizen is reporting*) **DATE SIGNED**

NOTARY: Subscribed and sworn to before me on this date: _____

NOTARY SIGNATURE _____ My commission expires: _____