555 Wright Way
Carson City, NV 89711
Reno/Carson City (775) 684-4DMV (4368)
Las Vegas (702) 486-4DMV (4368)
dmv.nv.gov

CONFIDENTIAL PHYSICIANS REPORT

PLEASE NOTE:
According to the Nevada Administrative Code, the Department of Motor Vehicles **MUST** receive this report within 30 DAYS after the date of the examination.
All fields are **MANDATORY**

Driver's License No: _____ Date of Birth (MM/DD/YYYY) _____

Phone Number: _____

Patient's Name: _____
Last First Middle

1. Diagnosis: _____

2. **In your opinion, will this medical condition affect the patient's ability to drive a vehicle safely?**
☐ Yes* ☐ No ☐ Uncertain* *If Yes or Uncertain, please explain:

3. Status of Patient's Medical Condition(s)*:
☐ Improving ☐ Stable ☐ Worsening or Deteriorating ☐ Subject to Change
**if multiple conditions exist, please describe status and prognosis.*

4. How long has this person been your patient?
_____ Years _____ Months Date of Last Examination: _____

5. Is your patient under a controlled medical program? ☐ Yes* ☐ No
**if Yes, how long has control been maintained?* _____ Years _____ Months

6. Is the patient adhering to the medical regimen? ☐ Yes ☐ No*
**if No, please explain:*

7. Is the patient knowledgeable about the medical condition? ☐ Yes ☐ No

8. Medications prescribed (please list type and dosage):

9. Will these medications affect the patient's ability to operate a motor vehicle safely?
☐ Yes* ☐ No *if Yes, please explain:

10. Does the nature of the condition indicate loss/lapse of consciousness, seizure activity, fainting or dizzy spells? ☐ Yes* ☐ No

***if Yes, please indicate the date (mm/dd/yyyy) of the last occurrence:** _____

10a. Was the seizure or loss of consciousness and isolated incident? ☐ Yes ☐ No

10b. Are additional seizures likely to occur? ☐ Yes ☐ No

11. Please recommend any restrictions you feel are necessary for this patient to safely drive a vehicle:

_____

_____

_____

_____

12. Physician's Comments:

_____

_____

_____ _____ _____

Date of Examination | Signature of Authorized Physician, APRN or PA | License Number

_____ _____

Physician Office Phone Number, APRN or PA | Please PRINT Name of Physician, APRN or PA

_____ _____ _____

Office Address of Physician, APRN or PA | City | State and Zip Code

I hereby authorize any physician, surgeon, advanced practical registered nurse, physician's assistant, or other person, and/or any clinic, or hospital, including the Department of Veterans Affairs or government hospital, to release any and all acquired medical information that specifically addresses the information on this form and may relate to, or affect my ability to operate a motor vehicle safely.

_____ _____

Patient's Signature | Date

OPTIONAL: You can have an indicator of a medical condition imprinted on your driver's license or identification card to alert police and medical personnel. Your physician must state on this form that you suffer from any of the medical conditions listed below. Check only one to be placed on the back of the license.

	Code	Description		Code	Description
	E934.2	Anticoagulants (adverse effect)		719.7	Difficulty in Walking
	F84.0	Autistic Disorder		389.9	Diminished Hearing
	369	Blindness and Low Vision		345.9	Epilepsy
	496	Chronic Airway Obstruction		995.6	Food Allergies
	414.1	Coronary Atherosclerosis		995.86	Malignant Hyperthermia
	389.1	Deafness			
	250.3	Diabetes			

You must present this form in person to the DMV if you wish to have one of these medical conditions imprinted on your driver's license or identification. There is no charge to have this added to your card, however, there will be a $3.25 fee to produce a new card.