NEW YORK STATE OF OPPORTUNITY. Department of Motor Vehicles

PHYSICIAN'S REPORTING FORM

INSTRUCTIONS:

- Please provide all of the information requested in **Parts 1 through 3** below, and sign and date the form.
- This form is provided for use by a physician, physician assistant, or nurse practitioner to report an individual whose driving ability may be affected due to some physical or mental impairment.
- This form must be completed and signed by a licensed physician, physician assistant or nurse practitioner.
- If additional assistance is needed, please contact the Medical Review Unit at (518) 474-0774, option #3. Hours are 8:30 am to 12:15 pm.
- If your patient is an older driver, you may also visit the Resources for the Older Driver website at dmv.ny.gov/olderdriver.
- Mail the completed form to: Medical Review Unit, NYS Department of Motor Vehicles, 6 Empire State Plaza, Room 337, Albany, NY 12228

Please Note: Based on the medical information submitted, our reviewer may ask for further medical details, or may request additional information from a pertinent sub-specialist, ex: cardiologist; neurologist

PART 1 - DRIVER IDENTIFICATION *(please print)*

** Required information*

Driver License Number			
Last Name*	First Name*	M.I.	Date of Birth (if not known, give approximate age)
Street Address			
City*	State		Zip Code

PART 2 - DESCRIPTION OF THE DRIVER'S CONDITION

Have you treated this patient? ☐ YES ☐ NO

If Yes: Date of Last Examination? _____

Please describe the condition that you have treated or are currently treating:

Is the patient receiving medication for this condition? ☐ YES ☐ NO

If Yes: Please specify the type and dosage:

In my medical opinion, (please check one):

☐ the patient's condition may affect the safe operation of a motor vehicle, and the patient should be evaluated by the Department of Motor Vehicles

☐ the patient's condition prevents the safe operation of a motor vehicle and driving privileges should be suspended.

Please provide further detail in the space provided or in an attached statement on your letterhead:

PART 3 - IDENTIFICATION AND CERTIFICATION OF THE PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER COMPLETING THIS REPORT

Your name (*Print name in full*)	Certificate or Lic. No.	Specialty *(Please specify)*	
Your Mailing Address (*Include Street & No.*)			State Where Licensed
City	State	Zip Code	(*Area Code*) & Telephone Number ( )
Your Signature (*Sign name in full*) X			Date (*Month/Day/Year*) / /

reset/clear