NORTH CAROLINA DIVISION OF MOTOR VEHICLES
Request for Driver Re-Examination

This request must provide specific information regarding the medical/visual condition and/or driving ability of the person in question and must be made only in the interest of public safety. Advanced age alone cannot be considered the sole reason for a re-examination request. Based on the information provided, the DMV Medical Review Unit will investigate and take action as necessary. Unsigned forms will not be accepted as a proper request and will not be acted upon. Due to confidentiality requirements, the Division is unable to release its final recommendation to you.

Name of Person Being Reported: _____ **Gender:** _____ **Date of Birth or Approx. Age:** _____

Driver License Number (if available): _____

Address: _____
Street

_____ _____ _____
City State Zip Code

Section for Healthcare Professional to complete:

Name: _____ **Phone Number:** _____

Address: _____
Street

_____ _____ _____
City State Zip Code

Underlying medical condition or diagnosis: _____

_____

Signature: _____ **Date:** _____

☐ Physician ☐ Vision Specialist ☐ Other

Section for Concerned Citizen to complete:

Name: _____ **Phone Number:** _____

Address: _____
Street

_____ _____ _____
City State Zip Code

Concern: _____

_____

Signature: _____ **Date:** _____

Mail this form to: DMV Medical Review Program, 3112 Mail Service Center, Raleigh, NC 27697
or fax it to: (919) 733-9569