OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

ALCOHOL / DRUG REINSTATEMENT

PLEASE PRINT OR TYPE

			FILE #	
LAST NAME	FIRST NAME		MI	DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP CODE	
PATIENT'S PHONE #	SOCIAL SECURITY # / DRIVER LICENSE #			

RELEASE OF INFORMATION

I, _____, hereby authorize and request information regarding my rehabilitation / treatment for chemical dependence on alcohol and / or any other drug of abuse be released to the Driver License Suspensions Section / Special Case Unit, Ohio Bureau of Motor Vehicles.

SIGNATURE **X**	DATE

STATEMENT FROM LICENSED PHYSICIAN, LICENSED PSYCHOLOGIST, CERTIFIED ALCOHOLISM COUNSELOR (CCDC II, CCDC III, or National Certified) OR PROBATION / PAROLE OFFICER.

The above individual has been denied driving privileges in the State of Ohio under provisions of statutory law Section 4507.08 of the Ohio Revised Code. This individual is now requesting that his / her driving privileges be restored. Before reinstatement can occur, it is necessary that the Registrar be in receipt of information which indicates that the individual has successfully completed a rehabilitation / treatment program AFTER the date of their last OVI / Drug offense AND maintained sobriety from alcohol and / or freedom from chemical dependence on any other drug of abuse for a continuous six (6) month period AFTER the treatment / rehabilitation program was completed. Please complete and return this form to the Ohio Bureau of Motor Vehicles, Attention: Driver License Suspensions Section / Special Case Unit, P.O. Box 16784, Columbus, Ohio 43216-6784.

NAME OF TREATMENT PROGRAM ATTENDED	DATE STARTED

☐ YES ☐ NO Inpatient Program Completed	DATE COMPLETED	DURATION
☐ YES ☐ NO Outpatient Program Completed	DATE COMPLETED	DURATION
☐ YES ☐ NO To the best of your knowledge, has the patient maintained a continuous six (6) month period of sobriety **AFTER COMPLETION** of the **INPATIENT / OUTPATIENT PROGRAM**?		

PLEASE NOTE: Do not sign this form until this person has maintained sobriety for six months after completion of the treatment program. Form must be returned to the bureau within ninety (90) days of its completion. Forms more than ninety days old will not be accepted.

PHYSICIAN, PSYCHOLOGIST, STATE OR NATIONAL CERTIFIED ALCOHOLISM COUNSELOR, OR PROBATION / PAROLE OFFICER.

NAME	TITLE	LICENSE #	
STREET ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE **X**	DATE	TELEPHONE #	

RESTRICTED