

SECTION 1 – To be completed by the **Information Source**

Name of Information Source (First, Middle Initial, Last)

(Area Code) Telephone Number



Wisconsin Department of Transportation • Medical Review PO Box 7918, Madison, WI 53707-7918

Telephone: (608) 266-2327 FAX: (608) 267-0518 Email: dmvmedical@dot.wi.gov

ZIP Code

State

Completion of this Pledge of Confidentiality indicates that you have information which questions a person's ability to safely operate a motor vehicle. It also indicates that you will not disclose the information to the Wisconsin Department of Transportation (WisDOT), including the driver's name, without a Pledge of Confidentiality. This pledge will remain confidential to the extent permitted by law. A court of competent jurisdiction could order the release of information otherwise held in confidence as a result of this pledge.

To be valid, this Pledge must be signed by a Wisconsin Department of Transportation representative prior to receiving the personally identifiable information about the driver. Information provided prior to completion of this Pledge, or not listed in this Pledge, or any subsequent information that is not identified in a Pledge of Confidentiality Agreement will not be considered confidential.

Address

City

Please give the reason the informa	ition will not be provided without a Pl	edge of Confidentiality:	
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	<u>X</u>	nformation Source Signature)	(5.1
	(1		(Date – m/d/yy)
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