NEW YORK STATE | Department of Motor Vehicles

PHYSICIAN'S STATEMENT FOR MEDICAL REVIEW UNIT

To Our Driver License Customer:

Use this form to report medical, physical, mental or a combination of such conditions to the Medical Review Unit.

Please complete the information below and have your physician/physician assistant/nurse practitioner complete the statement on **Page 2**.

IMPORTANT: The information provided must be based on a current examination performed by your physician/physician assistant/nurse practitioner within the last 120 days from the date this statement is submitted.

NOTE: Information provided by emergency care personnel is NOT acceptable. After review of the completed statement you may be requested to provide additional information from either the physician/physician assistant/nurse practitioner who provided the information or from a qualified specialist.

PLEASE PRINT OR TYPE

Last Name	First Name	M.I.	Date of Birth (Month/Day/Year)	☐ Male ☐ Female
			/ /	

Mailing Address (Number and Street)

City State Zip Code

Client ID No. (Driver License No.)	Any other names that you have used *(if applicable)*	Daytime Telephone Number (Area Code)
		( )

I am being treated and/or have been treated for the following medical, physical, or mental condition(s):

_____

_____

_____

_____

_____

Please check the appropriate box(es) below and fill in your physician/physician assistant/nurse practitioner's name:

☐ I am being treated primarily by my primary care physician, Dr. _____ .

☐ I am being treated primarily by my nurse practitioner, N.P. _____ .

☐ I am being treated primarily by my physician assistant, P.A. _____ .

☐ I am being treated by my specialist, Dr. _____ .

☐ I am being treated by my psychiatrist/psychologist, Dr. _____ .

Please have your physician/physician assistant/nurse practitioner complete page 2, and then return this form to:

Medical Review Unit
Driver Improvement Bureau
NYS Department of Motor Vehicles
6 Empire State Plaza
Albany, NY 12228
(518) 474-0774

PLEASE RECYCLE KEEP NEW YORK GREEN

THIS SIDE IS TO BE COMPLETED BY YOUR PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

Physician/Physician Assistant/Nurse Practitioner: Please attach a sample of your letterhead or a voided prescription blank.

PLEASE PRINT OR TYPE

Patient's Last Name	First Name	M.I.	Date of Birth (*Month/Day/Year*)	☐ Male ☐ Female
			/ /	

1. Examination Date (must be **within 120 days** from the date this form is submitted): ____/____/____
2. Condition patient is being treated for:

☐ Epilepsy/convulsive disorder ☐ Syncope/fainting/dizziness or a condition that causes unconsciousness ☐ Diabetes ☐ Sleep disorder
☐ Dementia/senility/Alzheimer's ☐ Head trauma/tumor ☐ Heart condition
☐ Stroke ☐ Neurological or neuromuscular disease ☐ Mental disorder
☐ Other *(please specify)* _____

3. Symptoms, severity, and frequency of condition: _____
4. Date of the last episode/incident associated with this condition: _____
5. Have any episode(s)/incident(s) associated with this condition caused any loss of consciousness, awareness, and/or body control?
☐ YES ☐ NO If YES, list the dates of the episode(s)/incident(s) _____
6. Give a brief description regarding any factors that may have caused/contributed to the episode(s)/incident(s): _____
7. To the best of your knowledge have any of the patient's episode(s)/incident(s) resulted in a motor vehicle accident(s) and/or incident(s)?
☐ YES ☐ NO If YES, please give details and the dates of the episode(s)/incident(s) and related accident(s): _____
8. Tests conducted (e.g., EEG, EKG, MRI, sleep study, serum levels, etc.): _____
9. Current treatment, medication and dosage, and /or therapy: _____

The following **MUST** be answered if the patient has a **sleep disorder**:

a.) Date first diagnosed with the sleep disorder: _____
b.) Is patient receiving treatment? _____ Type of treatment _____ Date treatment began: _____
c.) Is patient compliant with the treatment? _____

10. In my medical opinion, at this time (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.
☐ the patient's condition will not interfere with the safe operation of a motor vehicle.

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

_____
_____
_____

Physician/Physician Assistant/Nurse Practitioner's Name (*Please print in full*)	Certificate or license number and state where licensed
Physician/Physician Assistant/Nurse Practitioner's Mailing Address (*include number and street*)	Telephone Number (*area code*) ( )
City State Zip Code	☐ Primary care physician ☐ Neurologist ☐ Psychiatrist/Psychologist ☐ Physician/Physician Assistant/Nurse Practitioner ☐ Endocrinologist ☐ Other _____
Physician/Physician Assistant/Nurse Practitioner's Signature **X** **(Information provided by emergency care personnel is NOT acceptable.)**	Date (*Month/Day/Year*) / /