



STATE OF FLORIDA
DEPARTMENT OF HIGHWAY SAFETY
AND MOTOR VEHICLES

Medical Referral Form

Our agency is committed to complying with the Americans with Disabilities Act (ADA), a federal law which makes it unlawful to discriminate against a qualified person with a disability. Medical reviews are initiated based on medical conditions or symptoms that could affect the safe operation of a motor vehicle and not the age of the driver.

Sections 322.126(2) and (3), Florida Statutes, provide, in part, that "Any physician, person, or agency having knowledge of any licensed driver's or applicant's mental or physical disability to drive . . . is authorized to report such knowledge to the Department of Highway Safety and Motor Vehicles . . . The reports authorized by this section shall be confidential . . . No civil or criminal action may be brought against any physician, person or agency who provides the information herein."

When reporting an individual whose driving ability is questionable due to some physical or mental deficit or disorder, please complete as much of the information listed below as possible:

Name: _____

Date of Birth: _____

Address: _____

City: _____

Male Female

Zip Code: _____

Driver License Number: _____

State: _____

Physical or Mental Deficit or Disorder Noted:

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Severe Cardiac Condition | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Uncontrollable Diabetes | <input type="checkbox"/> Dementia/Memory Deficits |
| <input type="checkbox"/> Psychiatric Disturbance | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Severe Visual Deficit |
| <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Other | |

Please explain each area that was marked: _____

Please indicate how you know this individual (friend, family member, patient, etc.): _____



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Please provide your information (Note: The name and signature of the reporting person is required to investigate the report.)

Name of Law Enforcement Agency or Health Care Provider (if applicable): _____

Law Enforcement **ID/Badge #** or **Medical License #** (if applicable): _____

Mail this Completed Form to:
Bureau of Motorist Compliance
Medical Review Program
Neil Kirkman Building, MS 86
Tallahassee, Florida 32399-0500
Telephone No.: (850) 617-3814
Fax No.: (850) 617-3944

Name: _____

Signature: _____

Address: _____

Telephone: _____

Date of Report: _____