



## CUSTOMER MEDICAL REPORT

**Purpose:** Use this form to request medical information from your physician, physician assistant or nurse practitioner.

**Instructions:** Follow the detailed INSTRUCTIONS printed on page 2. Complete the Customer Information and Information Release Approval sections on this page. Take the entire MED 2 and DMV letter to your physician, physician assistant or nurse practitioner to complete the sections that pertain to your medical condition. Part F must be completed by your physician, physician assistant or nurse practitioner. Note: Any charges related to or incurred as part of the completion of this form are the customer's responsibility.

CUSTOMER INFORMATION							
NAME (Last)		(First)		(MI)	(Suffix)	CUSTOMER NUMBER (from your driver's license) or SSN	
RESIDENCE/HOME ADDRESS						<input type="checkbox"/> Check if this is a new address, your address will be changed on DMV's system.	
CITY				STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE	
MAILING ADDRESS (if different from above)							
CITY					STATE	ZIP CODE	DAYTIME TELEPHONE NUMBER
BIRTH DATE (mm/dd/yyyy)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		WEIGHT lbs		HEIGHT FT    IN		
Describe, in detail, your medical condition.							
Do you take prescription/non-prescription medications? <input type="checkbox"/> YES <input type="checkbox"/> NO    If Yes, list below. (attach a separate sheet if more space is required)							
NON-PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN	PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN		
Have you ever experienced a blackout, seizure, loss of consciousness, or syncope? <input type="checkbox"/> YES <input type="checkbox"/> NO    If Yes, enter date of last episode.			DATE (mm/dd/yyyy)		Did the episode result in a motor vehicle crash? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Explain what happened during the episode.							

### COMMERCIAL DRIVER LICENSE DISABILITY WAIVER OR HAZARDOUS MATERIALS VARIANCE

Are you applying for a commercial driver license disability waiver or a hazardous materials variance?    ☐ YES    ☐ NO

If YES, a CDL Disability Waiver or Hazardous Materials Variance Application (MED 30) must also be submitted.

### INFORMATION RELEASE APPROVAL

I authorize \_\_\_\_\_ and/or \_\_\_\_\_, a licensed medical provider to complete this Customer Medical Report, submit it to DMV and, if necessary to provide further clarification or information to DMV about my physical and/or mental condition. I consent to DMV using this information to arrive at a decision concerning my ability to safely operate a motor vehicle. I also authorize DMV to use the above customer information to correctly identify my records on file in accordance with the Virginia Privacy Protection Act of 1976. I understand that Virginia Code § 46.2-208(b)(1) prohibits DMV from releasing medical data to anyone other than a physician, physician assistant or nurse practitioner

CUSTOMER SIGNATURE AND AUTHORIZATION (parent must sign for a minor)

DATE (mm/dd/yyyy)



## CUSTOMER MEDICAL REPORT INSTRUCTIONS

**Purpose:** Use these instructions to complete the Customer Medical Report (MED 2).

### CUSTOMER INSTRUCTIONS

1. Review all correspondence received from the Department of Motor Vehicles (DMV) regarding concerns about your ability to safely operate a motor vehicle.
  - If you received an Official Notice/Order of Suspension, you must provide DMV with the required Customer Medical Report (MED 2), prior to the effective date noted in the Notice/Order to avoid having your driving privilege suspended.
  - If your driving privilege is suspended, you will be required to provide proof of legal presence in order to reinstate your driver's license, if you have not already provided proof.
2. Complete the sections of the MED 2 titled "Customer Information" and "Information Release Approval". Be sure to provide your signature at the end of the "Information Release Approval" section.
3. Take the entire MED 2 and your **DMV letter to your medical provider at the time of your medical examination.**
4. Request your medical provider to complete the parts of the MED 2 that pertain to your medical condition(s) **and** Part F and return the report to DMV (following medical provider instructions below).
  - The medical examination must be conducted after the issue date of your Official Notice/Order of Suspension.
  - If you were involved in a recent motor vehicle crash or have experienced a recent blackout, seizure or loss of consciousness, the MED 2 report must reference these incidents and/or events.

Note: you will be notified of any decisions regarding your driving privilege based on:

  - Medical and other related information received from your medical provider,
  - DMV driver license test results and/or a certified independent driver rehabilitation evaluation (if required),
  - DMV medical review policies and guidelines as established in collaboration with the DMV Medical Advisory Board.
5. If you have questions related to DMV's requirement for you to submit a MED 2, you may contact DMV Medical Review Services:
  - Mail - send your request in writing to Medical Review Services at the address listed at the top of this form
  - Telephone - (Voice) 1-804-367-6203 or (Deaf/Hearing Impaired only) 1-800-272-9268

## CUSTOMER MEDICAL REPORT INSTRUCTIONS

### MEDICAL PROVIDER INSTRUCTIONS

1. The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
  - ☐ level of consciousness/alertness
  - ☐ vision/perception
  - ☐ motor skills/range of motion
  - ☐ judgment/cognitive function
  - ☐ reaction time
2. DMV may have requested these documents for one of three reasons:
  - DMV received a crash report, Medical Review Request Form, or a court document that requires a medical evaluation. Please refer to the customer explanation letter that describes the issue of concern that needs to be addressed. Each form, A-E, has a section to complete regarding the issue. Please supply a medical opinion on the area of concern and attach any relevant lab work or test results.

If your patient was involved in a recent motor vehicle crash or has experienced a recent blackout, loss of consciousness, or seizure, the MED 2 must include specific information that may have contributed to the incident(s) and/or event(s).
  - DMV is requesting these forms for a patient we have under periodic review. Please be sure to address the patient's ongoing stability, any episode of instability, or any decline in the patient's condition. Please note any new conditions that may interfere with safe driving.
  - A patient self-reported on their application a medical condition or a medication that may indicate a medical condition that DMV evaluates for driver safety.
3. Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s).
  - For medical conditions, complete one or more of the following specific report sections:
    - ☐ Neurological/Musculoskeletal - Part A & F
    - ☐ Metabolic - Part B & F
    - ☐ Cardiovascular - Part C & F
    - ☐ Pulmonary - Part D & F
    - ☐ Psychiatric/Substance Abuse - Part E & F

NOTE: Only one Part F is required if the same medical provider completes multiple report sections.
4. In lieu of completing the MED 2, you may submit a letter, note or copies of records as long as the information you submit addresses all of the information requested on the MED 2 including your determination on the patient's ability and safety to drive.
5. Return the completed MED 2 to DMV by faxing it to DMV Medical Review Services at (804) 367-1604 or (804) 367-0520.
6. For additional information on DMV's medical review process, you may refer to [www.dmvnow.com](http://www.dmvnow.com) under "Citizen Services", then "Medical Information", or contact Medical Review Services at 804-367-6203.

# Customer Medical Report

MED 2 (02/25/2017)  
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NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:  
☐ level of consciousness/alertness   ☐ vision/perception   ☐ motor skills/range of motion   ☐ judgment/cognitive function   ☐ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

## PART A - NEUROLOGICAL/ MUSCULOSKELETAL REPORT (must also complete Part F)

<input type="checkbox"/> N/A for this customer		
Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
DIAGNOSIS(ES) (In order of severity or by current treatment)		
Are there any complications related to this/these condition(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain.		
Has the patient been hospitalized for the above condition(s) within the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, list dates hospitalized and status upon discharge.		
Was the hospitalization voluntary? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does the patient have a history of seizures? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, provide date of each episode and reason(s).		
Indicate the risk for further episodes.		
Did any seizure result in a motor vehicle crash? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, enter date of crash.	DATE OF CRASH (mm/dd/yyyy)	
Was the last medication blood serum level within acceptable range? <input type="checkbox"/> YES <input type="checkbox"/> NO   If No, provide results of blood test.	BLOOD TEST RESULTS	
Did the patient have a blackout or syncope? <input type="checkbox"/> YES <input type="checkbox"/> NO   If so, what was the cause? (Please enclose documentation to support the cause; such as results of lab work and blood pressures to support dehydration, high fever, etc.)		
Does the patient have any motor deficits/nerve problems that would impair his/her ability to drive? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does the patient have any other neurological condition(s) that might affect his/her driving? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, describe the condition(s) and its effect on the patient's driving.		
Does the patient have any chronic conditions, chronic pain syndromes, fibromyalgia or any movement disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, specify.		
Is the patient prescribed medication for chronic pain or long-acting narcotics? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, list the medication(s).		
Does the patient have the use of all extremities? <input type="checkbox"/> YES <input type="checkbox"/> NO   If No, which extremities are impaired?		
Does the patient suffer from peripheral neuropathy? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, which extremities are impaired?		
Current blood levels of anticonvulsant medication	TEST DATE (mm/dd/yyyy)	Results of most recent EEG
Does the neuropathy affect the patient's ability to safely operate a motor vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does the patient suffer from muscle spasms? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does the patient have full range of motion of the head and neck? <input type="checkbox"/> YES <input type="checkbox"/> NO   If No, describe range of motion.		
Is adaptive equipment recommended? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, what type of adaptive equipment does the patient require?		
If your patient is being seen for a particular incident, crash, or report provided to DMV, please provide relevant specific contributing information here.		

**Go to Part F**

# Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:

☐ level of consciousness/alertness   ☐ vision/perception   ☐ motor skills/range of motion   ☐ judgment/cognitive function   ☐ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

## PART B - METABOLIC REPORT (must also complete Part F)

<input type="checkbox"/> N/A for this customer		
Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO   IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
DIAGNOSIS(ES) (In order of severity or by current treatment)		
Are there any complications related to this/these condition(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain.		
Has the patient been hospitalized for the above condition(s) within the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, list dates hospitalized and status upon discharge.		
Was the hospitalization voluntary? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does the patient have diabetes or any other metabolic condition(s) that might affect vehicle operation? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, indicate condition.		
Do any complications or associated conditions exist? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain.		
Does this patient have hypoglycemic reactions? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, provide dates and reasons.		
Did the hypoglycemic reaction(s) result in a motor vehicle crash(es)? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does this patient demonstrate how to counter a hypoglycemic reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain how.		
Has this patient been hospitalized for treatment of diabetes/hypoglycemia or complications in the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain		
Does the patient monitor his/her blood sugar? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, how often?		
<p>Attach the following information/documents. If you suffered a hypoglycemic event, please ensure that your blood sugar logs reflect the last 15 days and your A1C results are drawn after the incident occurred and within the last 30 days.</p> <p>Blood Sugar Logs (15 days)   <input type="checkbox"/> Attached</p> <p>Hemoglobin A1C Results (30 days)   <input type="checkbox"/> Attached</p>		
If your patient is being seen for a particular incident, crash, or report provided to DMV, please provide relevant specific contributing information here.		

**Go to Part F**

# Customer Medical Report

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NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:  
☐ level of consciousness/alertness   ☐ vision/perception   ☐ motor skills/range of motion   ☐ judgment/cognitive function   ☐ reaction time  
 Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

## PART C - CARDIOVASCULAR REPORT (must also complete Part F)

<input type="checkbox"/> N/A for this customer	
Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, enter examination date.
EXAMINATION DATE (mm/dd/yyyy)	
DIAGNOSIS(ES) (In order of severity or by current treatment)	
Are there any complications related to this/these condition(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain.	
Has the patient been hospitalized for the above condition(s) within the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, list dates hospitalized and status upon discharge.	
Was the hospitalization voluntary? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does the patient have an implantable cardioverter defibrillator? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, give implant date.	
Has the unit discharged since the implant? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, describe the patient's condition at the time and date of discharge.	
Does the patient have a ventricular assist device system? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, when was this device implanted?	
Has the patient had any of the following:	
Cardiovascular surgery and/or other procedures? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain and give dates.	
Syncope? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain and give dates.  Fatigue with exertion? <input type="checkbox"/> YES <input type="checkbox"/> NO   Fatigue at rest? <input type="checkbox"/> YES <input type="checkbox"/> NO Dyspnea with exertion? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain and give dates.  Dyspnea at rest? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain and give dates.  Pulmonary symptoms? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain and give dates.	Attach the following information/documents: <input type="checkbox"/> Results of Event Monitor <input type="checkbox"/> Results of Holter Monitor <input type="checkbox"/> Results of Tilt-table Test <input type="checkbox"/> Results of EKG
If your patient is being seen for a particular incident, crash , or report provided to DMV, please provide relevant specific contributing information here.	

**Go to Part F**

# Customer Medical Report

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NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:  
☐ level of consciousness/alertness   ☐ vision/perception   ☐ motor skills/range of motion   ☐ judgment/cognitive function   ☐ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART D - PULMONARY REPORT (must also complete Part F)		
<input type="checkbox"/> N/A for this customer		
Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO   IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
DIAGNOSIS(ES) (In order of severity or by current treatment)		
Are there any complications related to this/these condition(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain.		
Has the patient been hospitalized for the above condition(s) within the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, list dates hospitalized and status upon discharge.		
Was the hospitalization voluntary? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is oxygen use required? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, describe treatment regimen and provide number of liters.		
Fatigue with exertion? <input type="checkbox"/> YES <input type="checkbox"/> NO   Fatigue at rest? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Dyspnea with exertion? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain and give dates.		
Dyspnea at rest? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain and give dates.		
Syncope from cough? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain cause and resolution.		
Does the patient have a diagnosis of sleep apnea, narcolepsy, or other sleep disorder? <input type="checkbox"/> YES <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe   (describe the treatment and submit a CPAP report for moderate to severe sleep apnea). <input type="checkbox"/> NO		
Does the pulmonary disease prevent activities of daily living? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, identify.		
Has patient been compliant with treatment to the extent that the symptoms are controlled? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Pulse oximetry <input type="checkbox"/> room air <input type="checkbox"/> oxygen		
Can the patient maintain O2 Saturation level of 90% or higher when driving? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Attach the following information/document if available <input type="checkbox"/> Results of pulmonary function test <input type="checkbox"/> Results of sleep study		
If your patient is being seen for a particular incident, crash , or report provided to DMV, please provide relevant specific contributing information here.		
<p style="text-align: center;"><b>Go to Part F</b></p>		

# Customer Medical Report

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NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:  
☐ level of consciousness/alertness   ☐ vision/perception   ☐ motor skills/range of motion   ☐ judgment/cognitive function   ☐ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART E - PSYCHIATRIC/SUBSTANCE ABUSE REPORT (must also complete Part F)		
<input type="checkbox"/> N/A for this customer		
Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
DIAGNOSIS(ES) (In order of severity or by current treatment)		
Are there any complications related to this/these condition(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, explain.		
Has the patient been hospitalized for the above condition(s) within the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, list dates hospitalized and status upon discharge.		
Was the hospitalization voluntary? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Has the patient been hospitalized in the past year for a mental/emotional condition? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, give admission date(s), reason(s) for admission and date (s) of discharge.		
Does the patient have a condition, which results in one or more of the impairments listed below? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, check all that apply.		
<input type="checkbox"/> Poor decision-making/problem-solving skills	<input type="checkbox"/> Hallucinations/delusions	<input type="checkbox"/> Poor/impaired judgement
<input type="checkbox"/> Memory loss, Cognitive	<input type="checkbox"/> Extremely aggressive/destructive behavior	<input type="checkbox"/> Dementia/confusion
<input type="checkbox"/> Poor impulse control/extremely impulsive	<input type="checkbox"/> Emotional or behavioral instability	
Identify current treatment program(s), counseling, medications, etc.		
Attach the following information/documents, (if available): MMSE <input type="checkbox"/> attached <input type="checkbox"/> not available Neuropsychological Exam <input type="checkbox"/> attached <input type="checkbox"/> not available		
Is patient CURRENTLY undergoing OR has patient successfully completed drug/alcohol treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, please provide name of program.		
Has the patient been compliant with substance abuse treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Attach the following information/documents: <input type="checkbox"/> Results of drug/alcohol screening <input type="checkbox"/> Report from substance abuse counselor <input type="checkbox"/> Recommendations:		
Did the patient experience seizure(s) related to withdrawal? <input type="checkbox"/> YES <input type="checkbox"/> NO   If Yes, give date(s).		
If your patient is being seen for a particular incident, crash , or report provided to DMV, please provide relevant specific contributing information here.		

Go to Part F



# Customer Medical Report

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(MUST BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER)

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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## PART F - GENERAL RECOMMENDATIONS

Is the patient's condition(s) stable? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain.		Is the patient compliant with treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain:											
Does the patient experience side effects of medications, which are likely to impair driving ability? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain:													
<p>Based on this examination, is the patient medically capable of:</p> <ul style="list-style-type: none"> <li>safely operating a motor vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO</li> <li>safely operating a motorcycle? <input type="checkbox"/> YES <input type="checkbox"/> NO</li> <li>safely operating a commercial motor vehicle includes tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials? <input type="checkbox"/> YES <input type="checkbox"/> NO</li> </ul>													
<p>Based on this examination, patient needs the following: (check each appropriate item)</p> <p><input type="checkbox"/> to be retested by DMV on <input type="checkbox"/> Knowledge <input type="checkbox"/> Road <input type="checkbox"/> Both <input type="checkbox"/> an adaptive device/equipment required to safely operate a motor vehicle.</p> <p><input type="checkbox"/> a driver evaluation (with a certified independent driver rehabilitation specialist CDRS). <input type="checkbox"/> a prosthetic/orthotic device to operate a motor vehicle</p> <p>For clarification on any of the above, contact Medical Review Services at 804 367-6203.</p>													
<p>Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)</p> <table border="0"> <tr> <td>Judgment and Insight</td> <td>Sensorimotor Function</td> </tr> <tr> <td><input type="checkbox"/> Problem Solving and Decision Making</td> <td><input type="checkbox"/> Strength and Endurance</td> </tr> <tr> <td><input type="checkbox"/> Emotional or Behavioral Stability</td> <td><input type="checkbox"/> Range of Motion</td> </tr> <tr> <td><input type="checkbox"/> Cognitive Function</td> <td><input type="checkbox"/> Maneuvering Skills</td> </tr> <tr> <td><input type="checkbox"/> Reaction Time</td> <td><input type="checkbox"/> Use of Arm(s) and/or Leg(s)</td> </tr> </table>				Judgment and Insight	Sensorimotor Function	<input type="checkbox"/> Problem Solving and Decision Making	<input type="checkbox"/> Strength and Endurance	<input type="checkbox"/> Emotional or Behavioral Stability	<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Cognitive Function	<input type="checkbox"/> Maneuvering Skills	<input type="checkbox"/> Reaction Time	<input type="checkbox"/> Use of Arm(s) and/or Leg(s)
Judgment and Insight	Sensorimotor Function												
<input type="checkbox"/> Problem Solving and Decision Making	<input type="checkbox"/> Strength and Endurance												
<input type="checkbox"/> Emotional or Behavioral Stability	<input type="checkbox"/> Range of Motion												
<input type="checkbox"/> Cognitive Function	<input type="checkbox"/> Maneuvering Skills												
<input type="checkbox"/> Reaction Time	<input type="checkbox"/> Use of Arm(s) and/or Leg(s)												
ADDITIONAL RECOMMENDED RESTRICTIONS		MEDICATIONS											
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)		MEDICAL SPECIALTY											
MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)	ISSUING STATE	TELEPHONE NUMBER										
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE			FAX NUMBER										
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE			DATE (mm/dd/yyyy)										

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.

Is the patient's condition(s) stable? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain.		Is the patient compliant with treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain:											
Does the patient experience side effects of medications, which are likely to impair driving ability? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain:													
<p>Based on this examination, is the patient medically capable of:</p> <ul style="list-style-type: none"> <li>safely operating a motor vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO</li> <li>safely operating a motorcycle? <input type="checkbox"/> YES <input type="checkbox"/> NO</li> <li>safely operating a commercial motor vehicle includes tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials? <input type="checkbox"/> YES <input type="checkbox"/> NO</li> </ul>													
<p>Based on this examination, patient needs the following: (check each appropriate item)</p> <p><input type="checkbox"/> to be retested by DMV on <input type="checkbox"/> Knowledge <input type="checkbox"/> Road <input type="checkbox"/> Both <input type="checkbox"/> an adaptive device/equipment required to safely operate a motor vehicle.</p> <p><input type="checkbox"/> a driver evaluation (with a certified independent driver rehabilitation specialist CDRS). <input type="checkbox"/> a prosthetic/orthotic device to operate a motor vehicle</p> <p>For clarification on any of the above, contact Medical Review Services at 804 367-6203.</p>													
<p>Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)</p> <table border="0"> <tr> <td>Judgment and Insight</td> <td>Sensorimotor Function</td> </tr> <tr> <td><input type="checkbox"/> Problem Solving and Decision Making</td> <td><input type="checkbox"/> Strength and Endurance</td> </tr> <tr> <td><input type="checkbox"/> Emotional or Behavioral Stability</td> <td><input type="checkbox"/> Range of Motion</td> </tr> <tr> <td><input type="checkbox"/> Cognitive Function</td> <td><input type="checkbox"/> Maneuvering Skills</td> </tr> <tr> <td><input type="checkbox"/> Reaction Time</td> <td><input type="checkbox"/> Use of Arm(s) and/or Leg(s)</td> </tr> </table>				Judgment and Insight	Sensorimotor Function	<input type="checkbox"/> Problem Solving and Decision Making	<input type="checkbox"/> Strength and Endurance	<input type="checkbox"/> Emotional or Behavioral Stability	<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Cognitive Function	<input type="checkbox"/> Maneuvering Skills	<input type="checkbox"/> Reaction Time	<input type="checkbox"/> Use of Arm(s) and/or Leg(s)
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PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)		MEDICAL SPECIALTY											
MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)	ISSUING STATE	TELEPHONE NUMBER										
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE			FAX NUMBER										
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE			DATE (mm/dd/yyyy)										

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.