



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

ALCOHOL/DRUG REINSTATEMENT

It is necessary that the Ohio Bureau of Motor Vehicles, Special Case/Medical Unit, receive information indicating you have completed a treatment/rehabilitation program and maintained a continuous six (6) month period of sobriety after the program was completed. The program must have been completed after the date of the last OVI and/or Drug offense.

The attached BMV 2326 form must be completed by one of the following: a licensed physician, licensed psychologist, or a certified alcoholism counselor (CCDC II, CCDC III, or National Certified). The person completing this form must vouch for your successful completion of a treatment/rehabilitation program and your continuous sobriety for at least six months AFTER completing treatment. The form BMV 2326 must be returned to the Ohio Bureau of Motor Vehicles within ninety (90) days of its completion. Failure to do so may result in your being required to have another form completed. You must complete the top portion of form BMV 2326, including the date and your written signature before presenting it to the physician, psychologist, or counselor for completion. When we have received the fully completed statement, you will be advised further.

Please be advised that, should your driving privileges be restored, and if you are convicted of a OVI within one (1) year from the date of restoration, the suspension will be reinstated.

Mail the completed form BMV 2326 to the following:

Ohio Bureau of Motor Vehicles
Attention: Special Case Section/Medical Unit
P.O. Box 16784
Columbus, OH 43216-6784
(614) 752-7500



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 Special Case Section, Ohio Bureau of Motor Vehicles.

X _____
SIGNATURE OF APPLICANT DATE

STATEMENT FROM LICENSED PHYSICIAN, LICENSED PSYCHOLOGIST, OR CERTIFIED ALCOHOLISM COUNSELOR (CCDC II, CCDC III, or National Certified)

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: Special Case Section/Medical Unit, P.O. Box 16784, Columbus, Ohio 43216-6784.

NAME OF TREATMENT PROGRAM ATTENDED	DATE STARTED
------------------------------------	--------------

<input type="checkbox"/> YES <input type="checkbox"/> NO Inpatient Program Completed	DATE COMPLETED	DURATION
<input type="checkbox"/> YES <input type="checkbox"/> NO Outpatient Program Completed	DATE COMPLETED	DURATION

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**? YES NO

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.

NAME ADDRESS AND TELEPHONE NUMBER OF PHYSICIAN, PSYCHOLOGIST, STATE OR NATIONAL CERTIFIED ALCOHOLISM COUNSELOR SIGNING FORM.

PLEASE PRINT OR TYPE

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