



DX / FILE NUMBER
PATIENT DRIVER LICENSE NUMBER

REQUEST FOR STATEMENT OF PHYSICIAN

PATIENT INFORMATION (Type or print in ink)

PATIENT FIRST NAME	LAST NAME	MI	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE
			PATIENT PHONE NUMBER

Check here if this is a name or address change.

RELEASE OF INFORMATION

I hereby authorize and request information regarding my physical and mental condition be released to the Driver License Division, Bureau of Motor Vehicles.

PATIENT SIGNATURE X	DATE
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PHYSICIAN'S STATEMENT

If new patient, are records of previous physician available? Yes No

PREVIOUS PHYSICIAN NAME			
ADDRESS	CITY	STATE	ZIP CODE

Is this patient being treated by another physician for any condition not being treated by you? Yes No

OTHER TREATING PHYSICIAN NAME			
ADDRESS	CITY	STATE	ZIP CODE

If yes, should the BMV contact the physician referenced above regarding driving privileges of this patient?

Yes No

Patient history and / or physical reveal the following:

- Yes No Vision abnormalities or eye disease (not correctable by eyeglasses)
- Yes No Musculoskeletal disorder (including loss of limb)
- Yes No Cardiovascular disease (e.g., Stroke, Angina, Heart failure, Hypertension)
- Yes No Respiratory disease (e.g., Emphysema, Asthma)
- Yes No Diabetes Mellitus and/or other Endocrine disorders
Insulin Dependent Yes No
- Yes No Neurological disease (e.g., Epilepsy, Multiple Sclerosis, Parkinson's disease)
- Yes No Impairment due to alcohol or drugs
- Yes No Psychiatric disorders
- Yes No Cognitive Impairment
- Yes No Other medical disorders which could interfere with driving ability

EXPLANATION REQUIRED FOR ALL ANSWERS ABOVE.

IMPLEMENTATION OF SECTIONS 4507.20; 4507.08 AND 4507.081 OHIO REVISED CODE, REQUIRES THE FOLLOWING INFORMATION BE PROVIDED:

1. How long has the condition(s) existed?

CONDITION	NO. OF YEARS	NO. OF MONTHS
CONDITION	NO. OF YEARS	NO. OF MONTHS

2. Give date of last episode or exacerbation.

CONDITION	YEAR	MONTH
CONDITION	YEAR	MONTH

2A. If #2 is not applicable, how long has the condition been under effective medical control?

CONDITION	NO. OF YEARS	NO. OF MONTHS
CONDITION	NO. OF YEARS	NO. OF MONTHS

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3. Is medication prescribed? Yes No If yes, please list medications.

1.	3.	5.
2.	4.	6.

4. If medication is prescribed, has your experience with this patient indicated that he / she can be depended upon to take the medication regularly and as instructed? Yes No

5. If you have discontinued patient's medication, give date of termination.

YEAR	MONTH
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6. In your professional opinion, is this patient's condition(s), on this date, sufficiently under effective medical control to operate a motor vehicle?

PLEASE NOTE: IF YOU ANSWER "YES" TO PARTS B, C, or D BELOW, THE EXAM WILL BE CONDUCTED NOW. THE EXAM(S) WILL BE CONDUCTED AT A DRIVER LICENSE EXAM STATION.

- A. Yes. This patient **should be permitted to** retain driving privileges.
- B. Yes. This patient **should be permitted to** retain driving privileges **only if** they can pass a partial driver license exam which consists of a vision screening and a road test for driving and maneuverability.
- C. Yes. This patient **should be permitted to** retain driving privileges **only if** they can pass a vision exam.
- D. Yes. This patient **should be permitted to** retain driving privileges **only if** they can pass a complete driver license exam which consists of a vision screening, written test of Ohio's laws and signs, and a road test for driving and maneuverability.
- E. No. This patient **should not be permitted to** retain driving privileges.

7. In your professional opinion, should this patient be reevaluated in the future for continued driving privileges.

Yes No

If yes, reevaluation is required:

- Once every six (6) months
- Once every year
- At time of driver license renewal (4 years or less depending on expiration date of current driver license or temporary permit)

(Print or type)

PHYSICIAN'S NAME	PHONE NUMBER	DATE	
ADDRESS	CITY	STATE	ZIP CODE
PHYSICIAN'S SIGNATURE X		PHYSICIAN'S LICENSE NUMBER	

NOTE TO PHYSICIAN: PLEASE MAKE A COPY FOR YOUR RECORDS.

OHIO BUREAU OF MOTOR VEHICLES, ATTN: SPECIAL CASE / MEDICAL UNIT, P.O. BOX 16784, COLUMBUS, OH 43216-6784