Please complete the Driver Condition Report if you have personal knowledge about a driver you believe is no longer able to safely operate a motor vehicle.

- You should report only your firsthand knowledge of the driver.
- You should complete the entire form and sign your name on the reverse side.
- After reviewing this report, the Director of Revenue may require the driver to take certain tests such as a medical, vision or driving test.
- All information contained in this report shall be kept confidential, unless released by a court order.

Describe in detail incidents or conditions about this driver. Give specific information such as dates, places, accident reports and all other available information to support the need for re-examination. You should report only information of which you have personal knowledge or physical evidence. Do not report what you have been told or heard.

LOCATION

DATE

TIME

[ ] Traffic Violations    [ ] Lack of Attention
[ ] Dangerous Actions    [ ] Caused Traffic Accident/Incident
[ ] Poor Driving Skills

[ ] Lack of Knowledge of Traffic Laws
[ ] Obstructing Traffic
[ ] Other ____________________________

______________________________

______________________________

______________________________

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______________________________
MEDICAL CONDITIONS

Please check the appropriate boxes if the driver being reported has any of the following conditions that would impair his or her ability to safely operate a motor vehicle:

☐ COGNITIVE IMPAIRMENTS/PSYCHIATRIC DISORDER
(i.e., sees or hears things that are not there, gets lost easily, has problems remembering words for common things, confusion in thought process or judgment)

Please explain: ________________________________

_________________________________________________________________________

_________________________________________________________________________

☐ VISUAL IMPAIRMENT
(frequently runs into objects, cannot see road signs, cannot see objects on the side without turning head)

Please explain: ________________________________

_________________________________________________________________________

_________________________________________________________________________

☐ ALCOHOL/DRUG ABUSE

Please explain: ________________________________

_________________________________________________________________________

_________________________________________________________________________

☐ DISORDERS THAT IMPAIR CONSCIOUSNESS
(i.e., seizures, blackouts, sleep disorders)

When was the last loss of consciousness?

[month] / [day] / [year]

Please explain: ________________________________

_________________________________________________________________________

_________________________________________________________________________

☐ LIMITED MOBILITY
(i.e., paralysis, problems moving freely)

Please explain: ________________________________

_________________________________________________________________________

_________________________________________________________________________

☐ OTHER CONDITIONS

Please explain: ________________________________

_________________________________________________________________________

_________________________________________________________________________

ADDITIONAL COMMENTS

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Please attach additional comments if necessary.

ANY PERSON WHO INTENTIONALLY FILES A FALSE REPORT SHALL BE GUILTY OF A CLASS A MISDEMEANOR, AND SHALL BE LIABLE FOR THE DAMAGES WHICH RESULT.

PERSON COMPLETING FORM:

PRINT FULL NAME (LAST, FIRST, MIDDLE)   RELATIONSHIP TO DRIVER   TELEPHONE NUMBER

STREET ADDRESS   CITY   STATE   ZIP CODE

SIGNATURE   DATE