MARYLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ADMINISTRATION

DC-118 (06/2019)

Driver Wellness & Safety Division SUBSTANCE USE TREATMENT PROVIDER'S REPORT

INSTRUCTIONS TO DRIVER: Complete Section A and have your Substance Use Treatment Provider complete the remainder of this form. The treatment provider should return this form with supporting documents to the MVA.

(Please note: Payment for any examination and preparation of this form is your responsibility.)

For questions call: 410-768-7553 for Reinstatement, or 410-768-7513 for Medical

SECTION A – TO BE COMPLETED BY DRIVER (Print or type)

Driver's License Number			Today's Date
Last Name	First	Middle	Date of Birth
Address			

SECTION B – TO BE COMPLETED BY TREATMENT PROVIDER

INSTRUCTIONS TO TREATMENT PROVIDER: The MVA has been made aware that the individual noted above may have an alcohol/substance use disorder that could affect their ability to safely drive. Please complete the remainder of this report. A licensed clinician must sign this report. Return this report and any supporting documentation by mail, fax, or email to:

Motor Vehicle Administration, Division of Driver Wellness and Safety, Room 124
6601 Ritchie Highway, NE, Glen Burnie, MD 21062, Fax 410-582-4936, Email DWSMED@mdot.maryland.gov

Note to Treatment Provider:

SECTION B – PROGRAM INFORMATION

1. Referred by: ☐ Court ☐ Drinking Driver Monitoring Program (DDMP) ☐ Lawyer ☐ MVA ☐ Self

2. Substance(s) Used
_____

3. Date Treatment Started _____ 4. Date Treatment Ended _____

5. _____ (enter number) ☐ Classes ☐ Hours ☐ Sessions

6. ASAM Level of Care: ☐ 0.5 ☐ 1 ☐ 2.1 ☐ 2.5 ☐ 3.1 ☐ 3.3 ☐ 3.7 ☐ 4
☐ Outpatient Treatment ☐ Licensed Health Professional in Solo or Group Practice

7. Attendance Requirements Met: ☐ Yes ☐ No 8. Overall participation: ☐ Good ☐ Fair ☐ Poor

Comments:

Treatment Provider's Report
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Name: _____ **Driver's License Number:** _____

SECTION B – ALCOHOL/DRUG TESTING

9. Tests Performed (***alcohol AND drug testing minimum twice monthly***): ☐ BAT ☐ UDS ☐ Other _____

9a. Twice monthly alcohol and drug screens were completed ☐ Yes ☐ No (If No, please comment)

9b. ☐ Positive screens noted below (attach additional pages if needed) ☐ All screens were negative

Date	Result	Date	Result	Date	Result
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Comments:

_____

_____

10. Prescription Medications: ☐ Yes (If Yes, please list) ☐ No

SECTION B - TREATMENT PROVIDER'S ATTESTATION

11. Description of present treatment plan:

12. Aftercare Recommended: ☐ Yes (If Yes, please comment) ☐ No

13. Additional Comments:

14: Treatment Facility Name: _____

15. License Type: ☐ Clinic ☐ Independent Practitioner ☐ Maintenance Clinic _____

16. Address: _____

17. Phone Number: _____ 18. Fax Number: _____

19: Name of Counselor/Licensed Clinician: _____

20. Counselor's Signature: _____ 21. Date: _____