MARYLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ADMINISTRATION

DC-119(09-19)

Driver Wellness & Safety Division Medical Provider's Report

INSTRUCTIONS TO DRIVER: Complete Section A and have your Physician/Medical Provider complete Section B. The medical provider should return this form to the MVA.
(Please note: Payment for any examination and preparation of this form is your responsibility.)

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

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

SECTION B – TO BE COMPLETED BY MEDICAL PROVIDER

INSTRUCTIONS TO MEDICAL PROVIDER: The MVA Driver Wellness and Safety Division has been made aware that the individual noted above may have a medical condition that could affect their ability to safely drive. Please complete the remainder of this report and return 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 Medical Provider: _____

_____

_____

HISTORY

DIAGNOSIS OR DISORDER (Please check all that apply)

Date of Incident/Diagnosis

☐ Diabetes with hypoglycemic event or DKA within the past year ..... _____
Complications: ☐ Diabetic retinopathy ☐ Peripheral neuropathy Most recent A1c _

☐ Lapse of consciousness, syncope, or blackouts ..... _____

☐ Seizure or Epilepsy ..... _____

☐ Cardiovascular condition associated with syncope ..... _____
Treatment includes: ☐ Pacemaker ☐ AICD

☐ Stroke or other cerebrovascular disease ..... _____
Residual impairment: ☐ No ☐ Yes, describe: _____

☐ Sleep disorder, including sleep apnea or narcolepsy ..... _____
Treatment _____ Compliant with treatment ☐ No ☐ Yes

☐ Vision deficiency with acuity worse than 20/70 or FOV worse than 110 degrees..... _____
Condition affects: ☐ Right eye ☐ Left eye ☐ Both eyes Condition is: ☐ Stable ☐ Progressive

Name: _____ **Driver's License Number:** _____

HISTORY Continued

Date of Incident/Diagnosis

☐ Traumatic brain injury within the past 2 years ..... _____

Residual impairment: ☐ No ☐ Yes, describe

☐ Dementia or cognitive impairment ..... _____

☐ Schizophrenia or mental health condition that may affect ability to safely drive ..... _____

☐ Poor decision making ☐ Hallucinations/delusions ☐ Impaired judgement ☐ Unstable emotional behavior

☐ Neuromuscular disorder causing weakness, shaking or numbness of extremities ..... _____

Uses assistive device for: ☐ Ambulation ☐ Driving

☐ Loss of impairment of a hand, arm, foot or leg ..... _____

If yes, describe _____

☐ Alcohol or drug dependency ..... _____

If yes, what drug(s) _____

Has the individual participated in alcohol/drug treatment program? ☐ Yes ☐ No

☐ Use of narcotic or habit-forming drugs .....

If yes, list _____

1. This individual is compliant with their treatment plan for the conditions noted above? ☐ Yes ☐ No (please comment)
2. The conditions noted above are stable. ☐ Yes ☐ No (please comment)
3. **Do any of the conditions noted above affect this individual's ability to safely operate a motor vehicle?**

☐ Yes (please comment) ☐ No ☐ Not Sure (please comment)

Comments/Pertinent Diagnostic Studies: _____

CURRENT DIAGNOSES AND MEDICATIONS

1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Name:_____ **Driver's License Number:**_____

FITNESS TO DRIVE SUMMARY

1. Do you have concern about this individual's ability to safely operate a motorvehicle?

☐ **Yes (please comment)** ☐ **No** ☐ **Unsure (please comment)**

2. Do you think additional assessment would help to determine the medical fitness to drive, such as Drive Test, Occupational Therapy Evaluation, Specialist Consultation, etc.?

☐ **Yes (please comment)** ☐ **No** ☐ **Unsure (please comment)**

Comments: _____

_____

_____

_____

MEDICAL PROVIDER ATTESTATION

1. How long has this individual been under your care? _____

2. What was the date of their last visit? _____

Name of Medical Provider _____

Specialty _____

Address _____

Phone Number_____ Fax Number _____

License State/Number _____

Medical Provider's Signature_____ Date _____