6601 Ritchie Highway, N.E. Glen Burnie, MD 21062 Motor Vehicle Administration	**PHYSICIAN/HEALTH CARE PROVIDER REPORT Driver Wellness & Safety Division**	**QUESTIONS? Please call: 410-768-7511 TTY FOR THE DEAF 1-800-492-4575 Visit our website at: www.MVA.Maryland.gov**

For Office Use Only. Requested By:_____ **Date Requested:**_____

TO THE DRIVER/APPLICANT: Please complete Section 1 below.

If information is filled in by the MVA, please check to see if it is accurate and make corrections. Your physician/health care provider completes the rest of this report. It should be returned to the MVA along with other forms that may have been sent with the cover letter that accompanied this form. Your physician/health care provider may choose to submit this report directly to the MVA. (Please note: Payment for any examination and preparation of this form is YOUR responsibility.)

Per Maryland Vehicle Law Transportation Article, Section 16-118, all medical information obtained will be kept CONFIDENTIAL and used to determine "the qualifications of an individual to drive." In some cases, "The Administration may use information in its records for the purpose of driver safety research, provided that personal information is not published or disclosed."

SECTION 1: GENERAL INFORMATION (To be completed by driver/applicant)

(Please Type or Print)

DRIVER/APPLICANT'S NAME _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP CODE

DATE OF BIRTH: _____ **PHONE NUMBER(S):** _____
MONTH / DAY / YEAR

DRIVER'S LICENSE NUMBER: _____ _____

PHYSICIAN/HEALTH CARE PROVIDER COMPLETES SECTIONS #2 - #7

TO THE PHYSICIAN/HEALTH CARE PROVIDER:

Your patient has self-reported a medical condition that may impact his/her fitness to drive safely or has been referred to the MVA because of a concern. There may be MVA notes below about this client and/or a request for specific information.

Please complete sections 2-7 of this form and give it to your patient for return to the MVA, OR, return the form by mail or fax to:

Motor Vehicle Administration
Division of Driver Wellness & Safety - Room 124
6601 Ritchie Highway, NE
Glen Burnie, MD 21062

Fax Number: 410-768-7627

MVA notes to the Physician/Health Care Provider: _____

_____

_____

_____

SECTION 2: HISTORY

In the past two years:

1. Has your patient been in any vehicle crashes/accidents? ☐ Yes ☐ No ☐ Unknown

1a. If YES, when? _____

2. Has your patient expressed any concern(s) about their medical fitness to drive ☐ Yes ☐ No ☐ Unknown

If YES, please explain: _____

3. Has your patient had any of the following? ☐ Loss of Consciousness (LOC) ☐ Seizure ☐ Syncope

Any LOC/altered state of consciousness requiring assistance _____

If YES, what was the date of the last episode? _____

4. Has your patient sustained a fall? ☐ Yes ☐ No ☐ Unknown

5. Have you treated this patient or referred him/her to another clinician for any of the following conditions that could affect driving? (Please use comment section to provide information.)

Yes	Date of Incident	
☐	_____	Diabetes that has caused a low blood sugar episode requiring assistance from another person in the last 6 months;
☐	_____	Epilepsy;
☐	_____	Seizure;
☐	_____	A heart condition that has caused a loss of consciousness in the past 6 months;
☐	_____	Stroke;
☐	_____	A condition that causes you to have dizzy spells, fainting, or blackouts;
☐	_____	Sleep apnea or narcolepsy;
☐	_____	A history of traumatic brain injury (TBI);
☐	_____	A conditon that causes weakness, shaking or numbness in the arms, hands, legs or feet that may affect your ability to drive;
☐	_____	A hand, arm, foot or leg that is absent, amputated, or has a loss of function that may affect your ability to drive;
☐	_____	An eye problem which prevents a corrected minimum visual acuity of 20/70 in at least one eye or binocular field of vision of at least 110 degrees;
☐	_____	Alcohol use problem;
☐	_____	Drug use problem;
☐	_____	A mental health condition that may affect your ability to drive;
☐	_____	Schizophrenia; or
☐	_____	Dementia.

Comment(s): _____

SECTION 3: CURRENT DIAGNOSES AND MEDICATIONS

CURRENT DIAGNOSES	CURRENT MEDICATIONS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

SECTION 4: DIAGNOSTIC STUDIES

Please provide results of diagnostic studies (laboratory, imaging, etc.) that are pertinent to conditions that can affect your patient's fitness to drive.

SECTION 5: PHYSICAL, COGNITIVE, MENTAL HEALTH STATUS

Does your patient have any cognitive, physical, or mental health problems that affect her/his ability to safely operate a motor vehicle?

☐ Yes ☐ No ☐ Not Sure

If YES, or Not Sure, please explain:

Does your patient require any of the following?

☐ cane ☐ walker ☐ wheelchair ☐ scooter ☐ portable oxygen

☐ adaptive equipment to drive other

SECTION 6: FITNESS TO DRIVE SUMMARY

1. For the conditions listed in Section 2, to your knowledge is your patient compliant with the treatment plan, including taking of medications and office appointments? Are the conditions stable and/or improving? If your answer is "NO" to either of these questions, please elaborate.

_____

_____

_____

2. Based on your evaluation of this patient, do you have any concern about his/her ability to safely operate a motor vehicle?

☐ Yes ☐ No ☐ Not Sure

3. If YES, or Not Sure, please explain:

_____

_____

_____

4. Do you think any additional assessment would help to determine your patient's medical fitness to drive?

☐ Yes ☐ No

If YES, please explain:

_____

_____

_____

SECTION 7: PHYSICIAN/HEALTH CARE PROVIDER ATTESTATION

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

2. What was the date of his/her last visit? _____

3. Name of Physician/Health Care Provider _____
(Print, type, or use stamp)

4. License Number _____ **5.** Specialty _____

6. Physician's Address: _____

7. Phone Number _____ **8.** Fax Number _____

9. Physician's Signature _____ **10.** Date _____