OHIO DEPARTMENT PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

REQUEST FOR STATEMENT OF PHYSICIAN

DX / FILE NUMBER
PATIENT DRIVER LICENSE NUMBER

PATIENT INFORMATION (Type or print in ink)

PATIENT FIRST NAME	PATIENT 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, Ohio Bureau of Motor Vehicles.

PATIENT SIGNATURE	DATE
X	

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, do you defer to the physician referenced above regarding the 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
☐ 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 of the 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. 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

4. 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 PART B, C, or D BELOW, THE EXAM WILL BE CONDUCTED NOW. THE EXAM(S) WILL BE CONDUCTED AT A DRIVER LICENSE EXAM STATION.

IF THIS PATIENT HOLDS A COMMERCIAL DRIVER LICENSE (CDL) AND YOU ANSWER "YES" TO PART B, C, OR D BELOW, CORRESPONDING TESTING FOR THE CDL CLASS AND ANY ENDORSEMENTS WILL BE CONDUCTED.

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.

5. 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.
   ☐ Once every four (4) years.

PHYSICIAN'S INFORMATION (type or print in ink)

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. The Patient will be advised who signed the form.

Please Return:

By Mail:	**By Email:**	**By Fax:**
Ohio BMV Attn: Special Case Unit P.O. Box 16784 Columbus, OH 43216-6784	BMV2310@dps.ohio.gov	Attn: Special Case Unit (614) 308-5211

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