MARYLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ADMINISTRATION

6601 Ritchie Highway, N.E. Glen Burnie, Maryland 21062

DC-220 (05-20)

Voluntary Physician/ Healthcare Provider Referral to the Maryland MVA

Note: This form is only to be used for a physician/healthcare provider referral of a driver to the Maryland MVA.

Patient's Name: (last)_____(first) _____(MI) _____

License Number (if known) ____ - ____ ____ ____ - ____ ____ ____ - ____ ____ ____ - ____ ____ ____

Please check any of the medical condition(s) below for which you have a concern in relationship to this individual's driving and provide an explanation. Note: Currently, The Code of Maryland (COMAR) (11.17.03.02; .02-1) informs a licensee or applicant for a driver's license that he/she "shall notify the Administration if the licensee or applicant is diagnosed as having any of the following disorders."

- ☐ 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 dizzy spells, fainting, or blackouts
- ☐ Sleep apnea or narcolepsy
- ☐ A history of traumatic brain injury (TBI)
- ☐ A condition that causes weakness, shaking, or numbness in the arms, hands, legs, or feet that may affect the ability to drive
- ☐ A hand, arm, foot, or leg that is absent, amputated, or has a loss of function that may affect the 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 the ability to drive
- ☐ Schizophrenia
- ☐ Dementia

Comments: _____

_____

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Patient's Name (last)_____ (first)_____(MI) _____

Street Address _____

City, State _____ ZipCode_____

Date of Birth: (month/day/year) _____ / _____ / _____

IMPORTANT: Do you recommend IMMEDIATE SUSPENSION of this individual's driving privilege until assessed by the MVA Medical Advisory Board?

Yes ☐ No ☐

Do you think the reported condition may improve and this individual will be a candidate to drive in the future?

Yes ☐ No ☐

If NO, please comment: _____

_____

Physician/Healthcare Provider Attestation:

1. How long has this individual been under your care? _____
2. Date of last visit (month/day/year) _____ / _____ / _____
3. Your name (print or stamp) _____
   ☐ MD/DO ☐ OPTOMETRIST ☐ NP ☐ PA ☐ RN ☐ DC ☐ PT/OT ☐ Other_____
4. License number _____ 5. Specialty _____
6. Address_____
7. Phone number_____ 8. FAX number _____
9. Physician/Healthcare Provider Signature_____
10. Date of this report (month/day/year) _____ / _____ / _____

This form may be submitted by mail, fax, or email

Maryland Motor Vehicle Administration
Driver Wellness and Safety Division
Attention: Nurse Case Review Manager
6601 Ritchie Highway, NE, Room 124
Glen Burnie, MD 21062

Fax: 410-582-4936 (**Phone:** 410-768-7513)

Email: dwsmed@mdot.state.md.us

Per Maryland Vehicle Law §16-119, 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."