

Driver Wellness & Safety Division Medical Provider's Report

Section A - To be completed by driver (print or type)

Driver License Number	Today's Date
Full Name	Date of Birth

INSTRUCTIONS TO DRIVER: This form is to be completed by your Physician/Medical Provider and returned to the MVA. All medical data obtained will be kept CONFIDENTIAL and will only be used for those purposes permitted by law.

For quickest processing, upload all documents securely to your myMVA account. You can create an account at <https://mymva.maryland.gov/go/web/CreateMyMVAProfile> or submit forms by mail to: MVA, 6601 Ritchie Highway NE, Room 124, Glen Burnie MD 21062.

Payment for any examination and preparation of this form is your responsibility.

Section B - Medical Provider Report

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. **See Note to Medical Provider (page 2), if applies.**

Diagnosis or disorder (Please check all that apply)	Date of Incident/Diagnosis
Diabetes with hypoglycemic event or DKA within the past year.....	_____
If yes, describe: _____	
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	
Condition is: Stable Progressive	
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	

Name	Driver's License Number
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History Continued

Date of Incident/Diagnosis

Neuromuscular disorder causing weakness, shaking or numbness of extremities _____

Use of assistive device for: Ambulation Driving

Loss or 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 _____

Note to Medical Provider

Current Diagnosis and Medications

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

1. This individual is compliant with their treatment plan for the conditions noted above? Yes No

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 Unsure (please comment)

Comments/Pertinent Diagnostic Studies:

