MARYLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ADMINISTRATION

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

DC-119 (09-24)

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

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:

Name	Driver's License Number

Fitness to Drive Summary

1. Do you have concern about this indivual's ability to safely operate a motor vehicle?

   ☐ 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