www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

CUSTOMER MEDICAL REPORT

Purpose: Use this form to request a medical review and information from your physician/nurse practitioner or ophthalmologist/optometrist.

Instructions: Refer to customer instructions below, and refer to pages 3 and 4 for physician/nurse practitioner or ophthalmologist/optometrist instructions. Print or type all information.

IMPORTANT

- If you change your residence/home address or mailing address to a non-Virginia address, your driver's license or photo identification (ID) card will be canceled.
- The information provided by the physician/nurse practitioner or ophthalmologist/optometrist must be based on an examination after the date of your official notice. In addition, if you were involved in a recent motor vehicle crash or have experienced a recent blackout, seizure or loss of consciousness, the physician's/nurse practitioner's report must reference these incidents or events.
- If you received a notice requiring medical and/or vision information, you are responsible for making sure that DMV receives the requested information prior to the due date listed in the notice. If your driving privilege is suspended, DMV will require that you provide proof of legal presence in order to reinstate your driver's license, if you have not already done so.

The decision regarding your driving privilege will be based on medical and other related information received, driver license test results (if required), as well as the Department of Motor Vehicle's (DMV) medical review policies and guidelines as established by the DMV Medical Advisory Board.

CUSTOMER INSTRUCTIONS

1. Complete the Customer Information Section on page 2.
2. In the Release Information section, print your physician's/nurse practitioner's name. Sign and date the form.
3. Have your physician/nurse practitioner complete this form as it pertains to your medical condition and/or mental health. Your physician/nurse practitioner will need to complete Section A and mail it to the Department of MotorVehicles(DMV) at the above address.

   If your notice indicates that DMV requires you to submit a vision report, have your ophthalmologist/optometrist complete Section B and mail it to DMV.

CONTACT INFORMATION

Contact Medical Review Services

1-804-367-6203 (Voice) 1-800-272-9268 (Deaf or Hearing Impaired Only) 1-804-367-1604 (Fax)

CUSTOMER MEDICAL REPORT

CUSTOMER INFORMATION

NAME (last) (first) (mi) (suffix)			DRIVER LICENSE OR SOCIAL SECURITY NUMBER
RESIDENCE/HOME ADDRESS ☐ check if this is a new address NOTE: If you check this box, your address will be changed on DMV's system.			
CITY	STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE
MAILING ADDRESS (if different from above)			
CITY	STATE	ZIP CODE	DAYTIME TELEPHONE NUMBER ( )
BIRTH DATE (mm/dd/yyyy)	GENDER ☐ MALE ☐ FEMALE	WEIGHT	HEIGHT FT IN

Describe, in detail, your medical condition.

Do you take prescription medications? ☐ Yes ☐ No If yes, list below

MEDICATION NAME	DOSAGE	TIME(S) TAKEN

Have you ever experienced a blackout, seizure, loss of consciousness, or syncope? ☐ Yes ☐ No If yes, enter date of last episode	Did the episode result in a motor vehicle crash? ☐ Yes ☐ No

Explain what happened during the episode.

Are you applying for a commercial driver license disability waiver or a hazardous materials variance? ☐ Yes ☐ No

RELEASE INFORMATION

I authorize _____ and/or _____, licensed physician/nurse practitioner and/or ophthalmologist/optometrist, to complete this certification, submit it to DMV and, if necessary to provide further clarification or information to DMV about my physical and/or mental condition. I consent to DMV using this information to arrive at a decision concerning my ability to safely operate a motor vehicle.

I also authorize DMV to use the above personal information to correctly identify my records on file in accordance with the Virginia Privacy Protection Act of 1976.

CUSTOMER SIGNATURE AND AUTHORIZATION (parent must sign for a minor)	DATE (mm/dd/yyyy)

CUSTOMER MEDICAL REPORT

TO BE COMPLETED BY A PHYSICIAN/NURSE PRACTITIONER ONLY
A letter, note, or copies of records may be sent in lieu of this form.

SECTION A: ☐ MEDICAL INFORMATION ☐ MENTAL HEALTH INFORMATION

CUSTOMER NAME (last) (first) (mi) (suffix)

DMV CUSTOMER NUMBER	BIRTH DATE (mm/dd/yyyy)	LENGTH OF TIME AS YOUR PATIENT	LAST EXAMINATION

DIAGNOSIS (briefly describe)

IS THERE A SIGNIFICANT PHYSICAL OR MENTAL DISORDER? ☐ Yes ☐ No If yes, provide details

PATIENT REQUIRED HOSPITALIZATION? ☐ Yes ☐ No

DATES HOSPITALIZED (mm/dd/yyyy) (enclose a copy of the discharge summary within three months.)
From _____ To _____

ADMITTANCE REASON

Patient mental/physical ability when released.

SEIZURE DISORDER? If yes, was episode due to Breakthrough seizure.
☐ Yes ☐ No ☐ Other (specify) _____

EPISODE DATE (mm/dd/yyyy)

Did the episode result in a motor vehicle crash? ☐ Yes ☐ No

Has the patient had a blackout, loss of consciousness, or syncope?
☐ Yes ☐ No If yes, was episode due to: ☐ Hypoglycemia
☐ Other (specify) _____

EPISODE DATE (mm/dd/yyyy)

Did the episode result in a motor vehicle crash? ☐ Yes ☐ No

PREVIOUS EPISODE(S) HISTORY

PATIENT IS COMPLYING WITH TREATMENT? ☐ Yes ☐ No If no, explain

EEG TEST DATE (mm/dd/yyyyy)	EEG RESULTS

PRESCRIBED MEDICATIONS (list all)

IN YOUR OPINION:
1. Patient is medically capable of safely operating a motor vehicle? ☐ Yes ☐ No
2. Patient needs retesting by DMV? (check applicable box) ☐ Yes ☐ No If yes, which tests? ☐ Knowledge ☐ Road Skills ☐ Both
3. Patient is mentally capable of safely operating a motor vehicle? ☐ Yes ☐ No
4. Patient needs a driver evaluation (with a certified driver rehabilitation specialist)? ☐ Yes ☐ No

ADAPTIVE EQUIPMENT REQUIRED? (for patient to drive) ☐ Yes ☐ No If yes, what equipment?

If the patient is applying to DMV for a commercial driver license disability waiver or a hazardous materials variance, please complete the following.

PATIENT REQUIRES PROSTHETIC/ORTHOTIC? ☐ Yes ☐ No If yes, describe the prosthetic/orthotic device.

ADAPTIVE DEVICES NEEDED? ☐ Yes ☐ No If yes, which devices?

ASSESSMENT In your opinion, patient is capable of safely operating a commercial motor vehicle? ☐ Yes ☐ No

PHYSICIAN/NURSE PRACTITIONER CERTIFICATION

PHYSICIAN/NURSE PRACTITIONER NAME (print)	PHYSICIAN/NURSE PRACTITIONER SIGNATURE		DATE (mm/dd/yyyy)
MEDICAL LICENSE NUMBER	LICENSE EXPIRATION DATE (mm/dd/yyyy)	STATE ISSUING LICENSE TO PRACTICE	
MEDICAL SPECIALTY	TELEPHONE NUMBER ( )	FAX NUMBER ( )	
BUSINESS ADDRESS	CITY	STATE	ZIP CODE

CUSTOMER MEDICAL REPORT

TO BE COMPLETED BY AN OPHTHALMOLOGIST/OPTOMETRIST
The examination should be conducted without the aid of a bioptic telescopic device.

SECTION B: VISION INFORMATION

CUSTOMER NAME (last) (first) (mi) (suffix)	DMV CUSTOMER NUMBER

When was the patient last examined by you?	May the Department of Motor Vehicles release the information you provide on this form to the patient? ☐ Yes ☐ No

	Right Eye	Left Eye	Both Eyes		Right Eye	Left Eye	Both Eyes
Visual Acuity Without Corrective Lenses	20	20	20	Horizontal Vision Field	°	°	°
Visual Acuity With Corrective Lenses	20	20	20	If One Eye Only	Temporal °	Nasal °	

Quadrant Defect ☐ OD ☐ OS ☐ OU	Hemianopic Defect ☐ OD ☐ OS ☐ OU	Central Scotoma Defect ☐ OD ☐ OS ☐ OU

Constricted Fields ____ °	Remaining OD ____ °	OS ____ °	Patient is Legally Blind ☐ OD ☐ OS ☐ OU

Does the patient have any visual defects/field loss that would affect the safe operation of a motor vehicle? ☐ Yes ☐ No If yes, explain

Is the patient's condition likely to deterioriate over the next 5 years? ☐ Yes ☐ No If no, explain

In your opinion, is the patient capable of safely operating a motor vehicle? ☐ Yes ☐ No If no, explain

In your opinion, is the patient capable of safely operating a commercial motor vehicle? ☐ Yes ☐ No If no, explain

Ophthalmologist/Optometrist recommendation(s)	Should the patient be required to periodically submit the results of a vision examination to DMV?
☐ Drive during daylight hours only ☐ Wear corrective lenses while driving	☐ Yes ☐ No If yes, how often?

OPHTHALMOLOGIST/OPTOMETRIST CERTIFICATION

OPHTHALMOLOGIST/OPTOMETRIST NAME (print)		LICENSE NUMBER	
BUSINESS ADDRESS	CITY	STATE	ZIP CODE
LICENSE EXPIRATION DATE (mm/dd/yyyy)	STATE ISSUING LICENSE TO PRACTICE	CHECK BOX THAT APPLY ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST	
TELEPHONE NUMBER ( )	FAX NUMBER ( )		
OPHTHALMOLOGIST/OPTOMETRIST SIGNATURE		DATE (mm/dd/yyyy)	