MDOT MARYLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ADMINISTRATION

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

DC-119 (04-23)

Driver Wellness & Safety Division Medical Provider's Report

INSTRUCTIONS TO DRIVER: Complete section A and have your physician/Medical Provider complete Section B. The medical provider should return this form to the MVA.

(Please note: Payment for any examination and preparation of this form is your responsibility)

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

Driver License Number			Today's Date
Last Name	First	Middle	Date of Birth
Address			

Section B - To be completed by medical provider

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 and return to:

To submit your forms electronically, please visit: https://mymva.maryland.gov/go/web/DocUpload

Or submit by mail at:
Motor Vehicle Administration, Division of Driver Wellness and Safety, Room 124,
6601 Ritchie Highway, NE, Glen Burnie, MD 21062

Note to medical provider:

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Diagnosis or disorder (Please check all that apply) **Date of Incident/Diagnosis**

Diabetes with hypoglycemic event or DKA within the past year.......................... ____________________

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

Name	Driver's License Number

History Continued

Date of Incident/Diagnosis

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

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 ____

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: ____

____

____

Current Diagnosis and Medications

1. ______________________________	1. ______________________________
2. ______________________________	2 . ______________________________
3. ______________________________	3 . ______________________________
4. ______________________________	4 . ______________________________
5. ______________________________	5 . ______________________________

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/Pertinent Diagnostic Studies: ______________________________

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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

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