



Treatment Provider's Report-Driver Wellness & Safety

QUESTIONS? Please call: (410) 768-7511
TTY FOR THE DEAF: 1-800-492-4575

For Office Use Only. Requested By: _____ Date Requested: _____

TO THE DRIVER/APPLICANT:

If you are currently being treated, or have been treated by a hospital clinic, alcohol or drug clinic, or some other type of treatment program or non-physician health care provider, please COMPLETE SECTION 1 (BELOW) ONLY; then have your treatment provider complete the rest of this form. This TREATMENT PROVIDER'S REPORT should be returned to us along with other forms that may be requested in the cover letter that accompanied this form. (Payment for any examination, if necessary, and the preparation of this form is YOUR responsibility).

All medical data obtained will be kept CONFIDENTIAL and will be used only to determine your qualifications to drive as set out in Section 16-118a of the Transportation Article of the Annotated Code of Maryland.

SECTION 1: GENERAL INFORMATION (To be completed by driver/applicant)

(Please Type or Print)

DRIVER/APPLICANT'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP CODE

DATE OF BIRTH: _____ **PHONE NUMBER(S):** _____
MONTH/DAY/YEAR

DRIVER'S LICENSE NUMBER: _____

TO THE TREATMENT PROVIDER:

Your client has been receiving care which requires review by the Medical Review Section and/or Medical Advisory Board. Please complete this TREATMENT PROVIDER'S REPORT and return it to this Administration along with your client's completed HEALTH QUESTIONNAIRE and any other required forms. Please complete all areas that pertain to your client. If you have any questions, you may contact the Medical Review Section at the above-listed phone number. If this information is not returned to our office, as specified in our cover letter to your client, his/her license/privilege to drive may be subject to suspension.

(Sections 2 and 3 to be completed by certified Treatment Provider)

SECTION 2: HISTORY

1. Date Treatment Started: _____

2. Date Treatment Will End: _____

3. Nature of the Program: Clinic Private Counseling

Other (please specify) _____

4. Referred by: Court Lawyer Relative(s) Friend(s) Self

Other (Please specify) _____

5. What is the required/recommended attendance? _____
 What is the individual's attendance? How often? _____ Regular attendance? _____ Irregular? _____
6. Does the individual recognize having a problem with alcohol? _____ Other drugs? (specify) _____

7. What is the individual's attitude and behavior concerning his/her problem? _____

8. Is the individual an active participant in the program? (please elaborate) _____

9. To your knowledge, is the individual maintaining complete abstinence from mind-altering chemical substances (alcohol and/or drugs)? Yes No
10. If the program includes urine or breathalyzer tests, please give dates of tests and results: _____

11. To your knowledge, is the individual taking any prescribed medication? Yes No
 If Yes, type: _____

SECTION 3: TREATMENT PROVIDER'S CERTIFICATION

1. Description of Limitation(s) - include any effect on your client's ability to safely operate a motor vehicle. (Please type or print):

2. Description of present treatment plan, contract or after-care program. (Please type or print):

3. Has the overall participation in the program been: Good? Fair? Poor?
4. Other Comment (Please type or print):

5. Name of Treatment Facility (Type or print): _____
6. Facility Address: _____ Phone Number: _____
7. Counselor/Treatment Representative (Print Name): _____
- (Signature) _____ 8. Date: _____



Apply to register to vote with your driver's license transaction. For details ask your customer agent.