



Voluntary Physician/ Healthcare Provider Referral to the Maryland MVA

Note: This form is only to be used for a physician/healthcare provider referral of a driver to the Maryland MVA.

Patient's Name: (last) _____ (first) _____ (MI) _____

License Number (if known) ____ - ____ - ____ - ____ - ____

Please check any of the medical condition(s) below for which you have a concern in relationship to this individual's driving and provide an explanation. Note: Currently, The Code of Maryland (COMAR) (11.17.03.02; .02-1) informs a licensee or applicant for a driver's license that he/she "shall notify the Administration if the licensee or applicant is diagnosed as having any of the following disorders."

- | | |
|--|--|
| <input type="checkbox"/> Diabetes that has caused a low blood sugar episode requiring assistance from another person in the last 6 months | <input type="checkbox"/> A hand, arm, foot, or leg that is absent, amputated, or has a loss of function that may affect the ability to drive |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> An eye problem which prevents a corrected minimum visual acuity of 20/70 in at least one eye or binocular field of vision of at least 110 degrees |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Alcohol use problem |
| <input type="checkbox"/> A heart condition that has caused a loss of consciousness in the past 6 months | <input type="checkbox"/> Drug use problem |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> A mental health condition that may affect the ability to drive |
| <input type="checkbox"/> A condition that causes dizzy spells, fainting, or blackouts | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Sleep apnea or narcolepsy | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> A history of traumatic brain injury (TBI) | |
| <input type="checkbox"/> A condition that causes weakness, shaking, or numbness in the arms, hands, legs, or feet that may affect the ability to drive | |

Comments: _____

Patient's Name (last) _____ (first) _____ (MI) _____

Street Address _____

City, State _____ ZipCode _____

Date of Birth: (month/day/year) _____ / _____ / _____

IMPORTANT: Do you recommend IMMEDIATE SUSPENSION of this individual's driving privilege until assessed by the MVA Medical Advisory Board?

Yes No

Do you think the reported condition may improve and this individual will be a candidate to drive in the future?

Yes No

If NO, please comment: _____

Physician/Healthcare Provider Attestation:

1. How long has this individual been under your care? _____

2. Date of last visit (month/day/year) _____ / _____ / _____

3. Your name (print or stamp) _____
MD/DO OPTOMETRIST NP PA RN DC PT/OT Other _____

4. License number _____ 5. Specialty _____

6. Address _____

7. Phone number _____ 8. FAX number _____

9. Physician/Healthcare Provider Signature _____

10. Date of this report (month/day/year) _____ / _____ / _____

This form may be submitted by mail, fax, or email

Maryland Motor Vehicle Administration
Driver Wellness and Safety Division
Attention: Nurse Case Review Manager
6601 Ritchie Highway, NE, Room 124
Glen Burnie, MD 21062

Fax: 410-768-7627 (Phone 410-768-7513)

Email: dwsmed@mdot.state.md.us

Per Maryland Vehicle Law §16-119, all medical information obtained will be kept CONFIDENTIAL and used to determine "the qualifications of an individual to drive." In some cases, "The Administration may use information in its records for the purpose of driver safety research, provided that personal information is not published or disclosed."



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