



State of Maine
Bureau of Motor Vehicles
DRIVER MEDICAL EVALUATION

Merrymeeting Driver Education
Topsham Campus

THIS SECTION TO BE COMPLETED BY DRIVER (Please print)

Name _____ Date of Birth _____
 Address _____ License/History Number _____
 _____ Telephone _____

TO BE COMPLETED BY APPROPRIATE MEDICAL OR PARAMEDICAL PROFESSIONAL (Clinician)

- Reason for Report:** To provide information to the Secretary of State regarding a possible physical, emotional or mental condition which could affect the driver’s ability to safely operate a motor vehicle. **Your report will be advisory** and used to assist in determining eligibility for a driver’s license.
- A Clinician Acting In Good Faith Is Immune** from damages claimed as a result of filing a Driver Medical Evaluation pursuant to 29-A MRSA Section 1258 (6). *The driver’s signature is not required to submit this form.*
- Please Refer To Functional Ability Profiles (FAP)** to assist you in completing this form. The rules are available at, <http://www.maine.gov/sos/bmv/licenses/medical.html>. Please **provide Profile Level(s)** for specified condition(s) or any other condition that may affect the driver’s ability to safely operate a motor vehicle.
- If You Have Any Questions** please call the Bureau of Motor Vehicles, Medical Section, at (207)624-9000, ext. 52124, or access the website; <http://www.maine.gov/sos/bmv/licenses/medical.html>

DIAGNOSIS

THIS SECTION MUST BE COMPLETED – PLEASE PRINT OR TYPE

FAP PROFILE LEVEL

CHECK **ONE** BOX PER DIAGNOSIS

	1	2	3A	3B	3C
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: If completing for Seizures, Stroke, or other Alteration/Loss of Consciousness, please describe and give date(s) for most recent episode(s). _____

For Chronic Pulmonary Disease, please provide oxygen saturation and indicate if measured while using oxygen or not.
 O2 Saturation _____ Without oxygen On oxygen

For Hypoglycemia requiring 3rd party intervention, please give date of most recent episode. _____
 Check here if patient has Hypoglycemic Unawareness.

If completing this form for Opioid Replacement Therapy/Prescription Medications and patient meets criteria for profile level 3c, please provide sub-category. (3c-i or 3c-ii) _____

For Substance Abuse profile level 3b, please document how long the patient has been substance free. _____

CLINICIAN COMMENTS

(Please describe deficits or impairments with potential to affect safe driving. Attach additional documentation, if needed.)

Please proceed to next page...

MEDICATIONS currently prescribed: (may attach med list)

Reliability in taking medications

Good Fair Poor Unknown No medication prescribed

Has patient reported or demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle? NO If yes, please describe _____

CERTIFICATE OF EXAMINATION (May be submitted without the patient signature)

Being duly licensed to practice in the state of _____ I hereby certify that I have examined this applicant.

(Clinician's signature)

(Degree & Specialty)

(Clinician's name printed or typed)

(Address)

(Office phone number)

(Office fax number)

DATE OF LAST EXAM
(Must be within past year or as specified by BMV)

(Signature Date)

Reply to:
Bureau of Motor Vehicles, Medical Section 29 State
House Station Augusta, Maine 04333-0029
Telephone (207)624-9000 ext. 52124
Please FAX completed form to: 207 624 9319

For assistance or to get a copy of the Functional Ability Profile rules, please go to:
<http://www.maine.gov/sos/bmv/licenses/medical.html> or call the Medical Section.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical history by _____ to the Secretary of State, Bureau of Motor Vehicles. I understand that this information may be shared with any qualified health care professional submitting information pertaining to the disclosed medical history for the purpose of determining my eligibility for a driver's license.

PATIENT SIGNATURE _____ **PHONE NUMBER** _____
DATE _____

Veterans please visit the Bureau of Veterans' Services website at <http://www.maine.gov/veterans> for information on state and federal benefits your military service may have earned you.