State of Maine

Bureau of Motor Vehicles

DRIVER MEDICAL EVALUATION

Merrymeeting Driver Education School
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)

1. **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.
2. **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.*
3. **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.
4. **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**
______________________________________	☐	☐	☐	☐	☐
______________________________________	☐	☐	☐	☐	☐
______________________________________	☐	☐	☐	☐	☐

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.