



DRIVER MEDICAL EVALUATION

THIS SECTION TO BE COMPLETED BY DRIVER (Please print) FOR QUESTIONS call (207)624-9000, ext. 52124

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

INFORMATION BELOW TO BE COMPLETED BY APPROPRIATE MEDICAL OR PARAMEDICAL PROFESSIONAL

- 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NOTE: For any Alteration/Loss of Consciousness, Seizure, Stroke, or Hypoglycemia episode requiring 3rd party intervention, please give date(s) and describe most recent episode(s) _____

For Chronic Respiratory Disease, please provide oxygen saturation and indicate if measured while using oxygen or not.
O2 Saturation _____ On room air On oxygen

For Hypoglycemia profile level 3b, please check appropriate sub-category. 3b.i. 3b.ii.

For Prescription Medications and/or Opioid Replacement Therapy and patient meets criteria for profile level 3c, please check appropriate profile level sub-category. 3c.i. 3c.ii.

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

CLINICIAN COMMENTS

(Please document if you are recommending restrictions, road test, or suspension of license, and describe deficits or impairments with potential to affect safe driving. Attach additional documentation if needed.)

Please proceed to next page...

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 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)

PROVIDE DATE OF LAST ASSESSMENT (Signature Date)

(Must be within past 12 months or as specified by BMV)

Reply to: Bureau of Motor Vehicles, Medical Section
29 State House Station
Augusta, Maine 04333-0029
Telephone: (207)624-9000 ext. 52124
E-mail: medical.bmv@maine.gov
Fax: (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 at (207)624-9000, 52124.

DRIVER 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 _____ **DATE** _____
E-MAIL _____ **PHONE NUMBER** _____

FOR QUESTIONS OR CONCERNS, call (207)624-9000, ext. 52124, or access the website:
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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.