State of Maine
Department of the Secretary of State
Bureau of Motor Vehicles
DRIVER MEDICAL EVALUATION

NAME: ____________________ DATE OF BIRTH: ____________________

ADDRESS: ____________________ LICENSE/HISTORY NUMBER: ____________________

____________________ PRINT DATE: ____________________

TELEPHONE #: ____________________

(Please Enter Phone Number)

CERTIFICATE OF EXAMINATION

FOR THE REPORTING PHYSICIAN:

1. This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition which could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office.

2. A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A MRSA Section 1258 (6).

FUNCTIONAL ABILITY PROFILE

Please complete the profile level for the listed conditions and provide information for any other conditions not listed below that may affect the driver's ability to drive a motor vehicle safely.

DIAGNOSIS **(PLEASE PRINT OR TYPE)** **If COPD Profile Level B or C provide 0_2 Sats ________.**	**PROFILE LEVEL** **THIS SECTION MUST BE COMPLETED** **CHECK ONLY ONE BOX PER DIAGNOSIS**						
	1.	**2.**	**3. A**	**3. B**	**3. C**	**3. D**	**4.**
____________________	☐	☐	☐	☐	☐	☐	☐
____________________	☐	☐	☐	☐	☐	☐	☐
____________________	☐	☐	☐	☐	☐	☐	☐

Date of last examination ____________________ How long has applicant been your patient? ____________________
(must be within past year)

For seizures/stroke or loss of consciousness give date of most recent episode____________________

Current prescribed medication(s): ____________________

____

☐ No medication prescribed

Reliability in taking medication
Good ☐ Fair ☐ Poor ☐ Unknown ☐

Has this patient demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle?

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MD-FR-24
02/12/2009
Rev. CR- 24 Form

* A copy of the rules can be viewed at www.maine.gov/sos/bmv/licenses/medical or a Functional Ability Profile booklet can be obtained by calling (207) 624-9000 extension 52124

PHYSICIAN'S COMMENTS

(Important - please describe physical and/or cognitive deficits.)

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Dr. ____or____Hospital

Signature of Patient: ____Date___________________________________
(Please forward this form directly to your physician for completion)

Patient Telephone number: ____

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

_______________________________ (Signature)	_______________________________ (Specialty)
_______________________________ (Physician's Name Printed or Typed)	_______________________________ (Address)
_______________________________ (Office Phone Number)	_______________________________ (Date)

Reply to: Medical Review Coordinator
Bureau of Motor Vehicles
29 State House Station
Augusta, Maine 04333-0029
Telephone: (207) 624-9000, ext 52124
Fax: (207) 624-9319

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