





# MEDICAL CONDITIONS

Please check  appropriate boxes if the driver being reported has any of the following conditions that would impair his or her ability to safely operate a motor vehicle:

**COGNITIVE IMPAIRMENTS PSYCHIATRIC DISORDER**  
(i.e., sees or hears things that are not there, gets lost easily, has problems remembering words for common things, confusion in thought process or judgment)

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**VISUAL IMPAIRMENT**  
(frequently runs into objects, can't see road signs, can't see objects on the side without turning head)

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ALCOHOL/DRUG ABUSE**

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**DISORDERS THAT IMPAIR CONSCIOUSNESS**  
(i.e., seizures, blackouts, sleep disorders)

Date of Last Event With Loss of Consciousness \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**LIMITED MOBILITY**  
(i.e., paralysis, problems moving freely)

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**OTHER CONDITIONS**

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## ADDITIONAL COMMENTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach additional comments if necessary.

## PERSON COMPLETING FORM:



**ANY PERSON WHO INTENTIONALLY FILES A FALSE REPORT SHALL BE GUILTY OF A CLASS A MISDEMEANOR AND SHALL BE LIABLE FOR THE DAMAGES WHICH RESULT.**

PRINT FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO DRIVER	TELEPHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE			DATE