State of Maine
Bureau of Motor Vehicles

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

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: 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.)

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Please proceed to next page…

MD-FR-24 (CR-24) Rev 05/01/23

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 _____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 *(Must be within past 12 months 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
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:
http://www.maine.gov/sos/bmv/licenses/medical.html

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.