DEPARTMENT OF TRANSPORTATION
DRIVER AND MOTOR VEHICLE SERVICES
1905 LANA AVE NE, SALEM OR 97314

DRIVER EVALUATION REQUEST

INSTRUCTIONS:

1. Complete this form when requesting Driver and Motor Vehicle Services (DMV) to re-evaluate a driver's ability to drive safely.
2. Sign this request in the signature block provided. Anonymous requests will not be honored.
3. Take completed request to a DMV office, mail, or fax to: DMV, Driver Safety Unit, 1905 Lana Avenue NE, Salem Oregon 97314. FAX: (503) 945-5329.

NAME OF PERSON TO BE RE-EVALUATED (last, first, middle)		ODL / CUSTOMER NUMBER	DATE OF BIRTH	
STREET ADDRESS	CITY		STATE	ZIP CODE

DMV may require re-evaluation only when there is reason to believe that a driver may no longer be qualified to hold a license. The individual may be required to take vision, knowledge or driving tests or obtain a medical clearance. In the space below, please provide specific information such as events, dates and places which caused you to question the individual's ability to drive safely. If you believe that the individual has a medical condition/impairment which impacts safe driving, please provide information about the condition/impairment and its impact on the individual's ability to safely operate a motor vehicle. The information provided on this report will help DMV identify the tests or clearance necessary to determine the driver's qualifications. (If additional space is needed, please use the back of this form.)

REQUESTS BASED ON AGE, DIAGNOSIS AND/OR GENERAL HEALTH ALONE WILL NOT BE HONORED.

☐ **Check here if you want your name kept confidential. DMV may not be able to keep this request confidential if the driver requests a hearing or files a lawsuit against DMV.**

YOUR RELATIONSHIP TO SUBJECT:

☐ Law Enforcement ☐ Physician ☐ Health Care Provider (explain): ____________________

☐ Relative ☐ Friend ☐ DMV Employee ☐ Court ☐ Other (explain): ____________________

YOUR NAME (please print)	SIGNATURE X		DATE
YOUR MAILING ADDRESS (city, state, zip code)		DAYTIME TELEPHONE NUMBER	FAX NUMBER

SECTION FOR MEDICAL PROFESSIONALS ONLY

Is the patient's condition progressive? ☐ Yes* ☐ No ☐ Unknown

If Yes*, do you recommend that DMV periodically re-evaluate the patient's qualifications to drive? ☐ Yes* ☐ No ☐ Unknown

If Yes*, when? ☐ in 6 months ☐ in 12 months ☐ in 24 months ☐ other: ____________________

If the reported impairments are severe and uncontrollable and you are the patient's primary care provider, please review the need for referral under Oregon DMV's Mandatory Reporting Program. Additional information can be found at: www.oregon.gov/ODOT/DMV/ATRISK.

SECTION FOR LAW ENFORCEMENT AGENCY OR COURT ONLY

Request is a result of: ☐ Traffic Accident (attach report) ☐ Traffic Stop	DATE OF INCIDENT	AGENCY PHONE NUMBER
What was the reason for contact with driver?		
Was the driver issued a traffic citation? ☐ YES ☐ NO	Citation for:	Is this request submitted instead of a citation? ☐ YES ☐ NO