



DRIVER'S LICENSE NUMBER

CDL/PS YES NO

MAIL TO: DMV, Driver Services Division, 60 State Street, Wethersfield, CT 06161-2510

INSTRUCTIONS: Under the provisions of Section 14-46 of the Connecticut General Statutes, any physician may report to the DMV, in writing, the name, age and address of any person diagnosed by him to have any chronic health problem which in the physician's judgment will significantly affect the person's ability to safely operate a motor vehicle, or to have recurrent periods of unconsciousness uncontrolled by medical treatment. Such reports shall be for the information of the commissioner in enforcing state motor vehicle laws, and used solely for the purpose of determining the eligibility of any person to operate a motor vehicle on the highways of this state.

PATIENT'S NAME: (Please Print or Type) _____ (Last) (First) (Initial)	DATE OF BIRTH: _____
PATIENT'S ADDRESS: _____	DATE OF EXAMINATION: _____

TYPE OF IMPAIRMENT:

- | | |
|--|---|
| <input type="checkbox"/> Alcohol/Substance Abuse _____ | <input type="checkbox"/> Ophthalmologic _____ |
| <input type="checkbox"/> Alzheimer's/Dementia _____ | <input type="checkbox"/> Orthopedic _____ |
| <input type="checkbox"/> Cardiovascular/Hypertension _____ | <input type="checkbox"/> Peripheral Vascular Disease _____ |
| <input type="checkbox"/> Cerebral Palsy _____ | <input type="checkbox"/> Psychiatric/Emotional Disorder _____ |
| <input type="checkbox"/> Cystic Fibrosis _____ | <input type="checkbox"/> Pulmonary/Sleep Apnea _____ |
| <input type="checkbox"/> Endocrine/Glandular _____ | <input type="checkbox"/> Spina Bifida _____ |
| <input type="checkbox"/> Liver/Renal Failure _____ | <input type="checkbox"/> Traumatic Brain Injury _____ |
| <input type="checkbox"/> Neurological/Neuromuscular _____ | <input type="checkbox"/> Other _____ |

OTHER IMPAIRMENT OR MEDICAL CONDITION: _____

PHYSICIAN'S COMMENTS:

PHYSICIAN'S CERTIFICATION: I certify that I have personally examined the above named person within the 90 days preceding completion of this report. I swear or affirm under penalty of false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, and subject to penalties for perjury for a deliberate false statement, that the above information and any attachment hereto is true and correct.

PHYSICIAN'S NAME: (Please print or type)	NAME OF HOSPITAL:	TELEPHONE NUMBER:	DATE OF REPORT:
PHYSICIAN'S SIGNATURE:	PHYSICIAN'S SPECIALTY:	PHYSICIAN'S LICENSE NUMBER:	STATE OF ISSUE: