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CONFIDENTIAL PHYSICIANS REPORT

PLEASE NOTE:
According to the Nevada Administrative Code, the Department of Motor Vehicles **MUST** receive this report within 30 DAYS after the date of the examination.
All fields are **MANDATORY**

Driver's License No: _____ Date of Birth (MM/DD/YYYY) _____

Phone Number: _____

Patient's Name: _____
Last First Middle

1. Diagnosis: _____

2. **In your opinion, will this medical condition affect the patient's ability to drive a vehicle safely?**
☐ Yes* ☐ No ☐ Uncertain* *If Yes or Uncertain, please explain:

3. Status of Patient's Medical Condition(s)*:
☐ Improving ☐ Stable ☐ Worsening or Deteriorating ☐ Subject to Change
**if multiple conditions exist, please describe status and prognosis.*

4. How long has this person been your patient?
_____ Years _____ Months Date of Last Examination: _____

5. Is your patient under a controlled medical program? ☐ Yes* ☐ No
**if Yes, how long has control been maintained?*
_____ Years _____ Months

6. Is the patient adhering to the medical regimen? ☐ Yes ☐ No*
**if No, please explain:*

7. Is the patient knowledgeable about the medical condition? ☐ Yes ☐ No

8. Medications prescribed (please list type and dosage): _____

9. Will these medications affect the patient's ability to operate a motor vehicle safely?
☐ Yes* ☐ No *if Yes, please explain:

10. Does the nature of the condition indicate loss/lapse of consciousness, seizure activity, fainting or dizzy spells? ☐ Yes* ☐ No

***if Yes, please indicate the date (mm/dd/yyyy) of the last occurrence:** _____

10a. Was the seizure or loss of consciousness and isolated incident? ☐ Yes ☐ No

10b. Are additional seizures likely to occur? ☐ Yes ☐ No

11. Please recommend any restrictions you feel are necessary for this patient to safely drive a vehicle:

_____

_____

_____

_____

_____

12. Physician's Comments: _____

_____

_____

Date of Examination | Signature of Authorized Physician, APRN or PA | License Number

Physician Office Phone Number, APRN or PA | Print Name of Physician, APRN or PA

Office Address of Physician, APRN or PA | City | State and Zip Code

I hereby authorize any physician, surgeon, advanced practical registered nurse, physician's assistant, or other person, and/or any clinic, or hospital, including the Department of Veterans Affairs or government hospital, to release any and all acquired medical information that specifically addresses the information on this form and may relate to, or affect my ability to operate a motor vehicle safely.

Patient's Signature | Date

OPTIONAL: To have a medical indicator on your license or identification card to alert police and medical personnel, your physician must state on this form that you suffer from one of the medical conditions listed below. **Check only one.**

The medical indicator includes a blue medical symbol on the front and one medical code printed on the back of your driver's license or identification card.

	Code	Description		Code	Description
☐	E934.2	Anticoagulants (adverse effect)	☐	389.9	Diminished Hearing
☐	299	Autistic Disorder	☐	345.9	Epilepsy
☐	369.00	Blindness and Low Vision	☐	995.6	Food Allergies
☐	496	Chronic Obstruction Pulmonary Disease	☐	286.52	Hemophilia
☐	414.01	Coronary Atherosclerosis	☐	995.86	Malignant Hyperthermia
☐	389.10	Deafness	☐	310.9	Mental Illness
☐	311	Depression	☐	295.5	Schizophrenia
☐	250.9	Diabetes	☐	282.6	Sickle-Cell
☐	719.7	Difficulty in Walking	☐	710.0	Systemic Lupus Erythematosus

You must present this form in person to the DMV if you wish to have one of these medical conditions imprinted on your driver's license or identification with the medical indicator symbol on the front. There is no charge to have this added to your card, however, there will be a $3.25 fee to produce a new card.