OFFICE OF THE SECRETARY OF STATE
DRIVER SERVICES DEPARTMENT

DRIVER ANALYSIS DIVISION
2701 S. DIRKSEN PARKWAY
SPRINGFIELD, IL 62723
217-782-7246
ILSOS.GOV

Medical Report For Conditions That May Impair Driving Safely

Please see guidelines at ilsos.gov, search for Medical/Vision Conditions for completion of form.

SECTION I — To be completed by driver. (Please print or type.)

Name: _____ Driver's License Number: _____
Last First Middle

Street Address: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ X
Month Day Year

City: _____ ZIP : _____ Ph: (_____)_____

Agreement/Release of Information

I agree to remain under the care of my physician and follow the treatment exactly as prescribed. I hereby authorize and request my physician to release information regarding my medical condition to the Illinois Secretary of State, and to report any change in the status of my condition that would impair my ability to safely operate a motor vehicle. I understand that failure to abide by the conditions outlined in this agreement will be grounds for the Secretary of State to deny or cancel my driving privileges. ***THIS REPORT IS VALID FOR THREE MONTHS (90 DAYS).***

_____ _____
Signature of Individual Date of Signature

SECTION II MEDICAL HEALTH — To be completed by MD/DO and/or medical professional (NP/PA).

DATE OF COMPLETION OF MEDICAL HEALTH SECTION II: _____

1. **Required: In your professional opinion, is this individual MEDICALLY AND MENTALLY FIT to safely operate a motor vehicle?** **YES** ☐ **NO** ☐

2. Conditions: Yes or No required for each condition listed.
   - (a) Cardiovascular YES ☐ NO ☐ (provide condition)_____
     (NA for Hypertension or Hyperlipidemia)
   - (b) Neurological YES ☐ NO ☐ (provide condition)_____
   - (c) Musculoskeletal YES ☐ NO ☐ (provide condition)_____
   - (d) Seizures YES ☐ NO ☐ (provide condition)_____
   - (e) Diabetes YES ☐ NO ☐
   - (f) Dizzy/Fainting Spells YES ☐ NO ☐
   - (g) Alcohol/Drug Abuse YES ☐ NO ☐
   - (h) Developmental YES ☐ NO ☐ (provide condition)_____
   - (i) Mental YES ☐ NO ☐ (provide condition)_____
   - (j) Other Condition(s) YES ☐ NO ☐ (provide condition) _____

3. (a) **LIST ALL current medications and dosages (including medications prescribed by another physician). If medications are listed, a condition must be disclosed above (in Question #2).** _____
   _____
   _____
   (b) Does the patient have side effects from any medication(s) that would impair the driver's ability to safely operate a motor vehicle?
   YES ☐ Explain_____ **NO** ☐
   (c) Is the driver compliant with medication and treatment regime? YES ☐ NO ☐ Explain _____
   _____
   (d) ☐ No medications prescribed.

(continued on back)

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PATIENT'S NAME: _____

4. **Required:** Current Status of Condition:
(A) Controlled ☐ (B) Not Controlled: **will not affect driving** ☐ (C) Not Controlled: **may affect driving** ☐
(If Not Controlled is marked, you must provide details, which may include pertinent clinical information, i.e., test results, lab values.)

_____

5. **Required:** In the past six months, has the driver's ability to safely operate a motor vehicle been impaired (for any reason), or has the driver experienced an attack of unconsciousness? YES ☐ NO ☐ Date of Attack: _____
(If YES, you must provide details, which may include pertinent clinical information.)

_____

_____

6. Date of last impaired ability to safely operate a motor vehicle or attack of unconsciousness. Date: _____
(You must provide details, which may include pertinent clinical information.)

_____

_____

SECTION III — PROVIDER

1. How long have you been treating this driver? _____
2. Is the driver being treated by any other providers? YES ☐ NO ☐
3. If Question 2 is YES, name of physician and contact information: _____

_____

_____

NOTE: If treated by another provider, a statement regarding medical and mental fitness to operate a motor vehicle or a completed Medical Report is required by that provider.

SECTION IV — Additional information, special restrictions, etc.

_____

_____

_____

SECTION V — MD/DO and/or medical professional (NP/PA) — Failure to provide license information will result in return of form to the driver.

(Unacceptable Signatures: Chiropractors, Podiatrists, Residents, Fellows, Interns, RN's, LPN's, Co-signatures)

MEDICAL:

_____ _____
Provider Name (**PRINTED**) Medical Provider's Address (**PRINTED/STAMPED**)

_____ ( ) _____
Professional License Number/State License Issued Telephone Number

_____ _____
Provider's **SIGNATURE** — Date of Completion ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** Provider's Specialty

OTHER PROVIDER:

_____ _____
Provider Name (**PRINTED**) Medical Provider's Address (**PRINTED/STAMPED**)

_____ ( ) _____
Professional License Number/State License Issued Telephone Number

_____ _____
Provider's **SIGNATURE** — Date of Completion ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** Provider's Specialty

PLEASE MAINTAIN A COPY FOR YOUR RECORDS.