CONFIDENTIAL

FOR OFFICE USE ONLY

MVID # ____________________

DRIVER MEDICAL EVALUATION

Instructions: *Print clearly and legibly. If any section of this form is incomplete, it may be returned to the medical professional for completion. If this evaluation is needed to meet annual requirement, it must be from an examination within last 3 months.*

APPLICANT INFORMATION

APPLICANT FULL NAME (Printed)	DRIVER LICENSE NUMBER
MAILING ADDRESS (including city, state, zip)	DATE OF BIRTH

MEDICAL SECTION

THIS FORM MAY ONLY BE COMPLETED & SIGNED BY A *QUALIFIED MEDICAL PROFESSIONAL *(*Definition: A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.")*

IN MY PROFESSIONAL OPINION (*mark only one option)

☐ 1. This patient is **not** medically, physically, or mentally capable of safely operating a motor vehicle. *(Based on Wyoming Statute 31-7-123 and Department Rules and Regulations, this option will result in the cancellation or denial of the applicants driver license.)*

☐ 2. This patient was previously afflicted with a medical disorder resulting in a loss, interruption, or lapse of consciousness and/or motor function; however, this patients affliction no longer exists or is medically controlled.

☐ 3. This patient **is** medically, physically, and/or mentally capable of safely operating a motor vehicle; however, the following should be required *(for #3 only, please check all that apply below):*

- ☐ the following restrictions should be placed on the applicant's driver license: ☐ NONE
  - ☐ AUTOMATIC TRANSMISSION ☐ NO INTERSTATE DRIVING
  - ☐ DAYLIGHT DRIVING ONLY ☐ SPECIFIC LIMITS OF SPEED ZONE OR DISTANCE: ____________________
  - ☐ PROSTHETIC AIDE: ____________________
  - ☐ SPECIAL ADAPTIVE DEVICES/EQUIPMENT: ____________________
  - ☐ OTHER RESTRICTIONS: ____________________
- ☐ I recommend this patient be required to complete a driving road test to determine if patient meets licensing standards.
- ☐ I recommend this patient be required to submit a "Driver Medical Evaluation" annually to the Department.

ADDITIONAL COMMENTS

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NOTE: *Wyoming Statute 31-7-123 and Department Rules and Regulations give the Department authority to cancel a person's driver license and/or deny a driver license to a person who has a medical condition that, in the opinion of qualified medical professional, results in the patient's inability to safely operate a motor vehicle. The information contained in this report is* ***confidential*** *and will be used only to determine eligibility/restrictions for licensing.*

By signing below, I certify that I am a qualified medical professional as defined above and that I have examined the applicant.

PRINT NAME OF QUALIFIED MEDICAL PROFESSIONAL	CLASSIFICATION/SPECIALITY	MEDICAL LICENSE NUMBER
MAILING ADDRESS (including city, state, zip)	CONTACT PHONE NUMBER	CONTACT FAX NUMBER
AUTHORIZED SIGNATURE		DATE

Should you have any questions regarding this form, please contact a Driver Review Representative at 307-777-4839.

Mail to: Wyoming Department of Transportation (WYDOT)
Driver Services - Driver Review Section
5300 Bishop Boulevard, Cheyenne, WY 82009-3340

OR Fax to: 307-777-4922
OR Email to: dot-medicals@wyo.gov
http://www.dot.state.wy.us/home/driver_license_records.html