

## ALCOHOL/SUBSTANCE ABUSE ASSESSMENT FOR RE-LICENSING



### CLIENT INFORMATION

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

**COUNSELOR:** The Wyoming Department of Transportation has evidence that the above client has or has had an alcohol and/or controlled substance abuse problem. This applicant must complete an investigation to determine if he/she can be re-licensed. If allowed to be re-licensed, the following restriction will be added to the client's driver license: "No alcohol and/or controlled substance offenses, and must follow counselor's recommendations." We are requesting that you monitor the individual's compliance with the requirements and/or recommendations **and** report any non-compliance.

**THIS FORM MAY ONLY BE COMPLETED & SIGNED BY A LICENSED ADDICTION COUNSELOR CERTIFIED BY THE WYOMING DEPARTMENT OF HEALTH SUBSTANCE ABUSE PROGRAM.** (<https://improv.health.wyo.gov/MHSAPublicProviderSearch.aspx?Map=T>)

### RE-LICENSING RECOMMENDATIONS/REQUIREMENTS (check all that apply and please *do not* abbreviate)

On the basis of my evaluation concerning this client's use of alcohol and/or a controlled substance(s), I recommend:

	FREQUENCY	DURATION	SCHEDULED/COMPLETION DATE
<input type="checkbox"/> Group Therapy			
<input type="checkbox"/> Individual Therapy			
<input type="checkbox"/> Intensive Outpatient Treatment			
<input type="checkbox"/> Inpatient Treatment			
<input type="checkbox"/> Ignition Interlock			

### OTHER RECOMMENDATIONS

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### In my professional opinion

- this patient's condition does not affect his/her ability to safely operate any type of motor vehicle.
- this patient's condition renders him/her incapable of safely operating any type of motor vehicle.

*I agree to follow the above recommendations and/or requirements. I understand that if I do not comply with these licensing requirements/recommendations, my valid driver license will be cancelled and/or I will be denied application for a driver license.*

CLIENT'S SIGNATURE	DATE
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**IMPORTANT NOTE:** This assessment must be completed **no earlier than 90 days** from the client's re-licensing eligibility date. Clients who do not follow their counselor's recommendations and/or requirements should be reported in writing to Driver Services' Driver Review Section.

PRINT NAME OF CERTIFIED COUNSELOR	NAME OF COUNSELING SERVICE
MAILING ADDRESS (including city, state, zip)	CONTACT PHONE NUMBER
COUNSELOR SIGNATURE	DATE

Should you have any questions regarding this form, please contact the Customer Service Desk at 307-777-4800.

Return completed form to: **Wyoming Department of Transportation (WYDOT)** OR Fax to: **307-777-4922**

**Driver Services - Driver Review Section**

**5300 Bishop Boulevard, Cheyenne, WY 82009-3340**