Medical Evaluation for Driver License Mail Renewal

Form 2 of 3

ATTN: RNRP P.O. Box 201430 Helena, MT 59620-1430 ● Phone (406) 444-1352 ● Fax (406) 444-2086 ● www.doj.mt.gov

Driver's Legal **Last** Name	Driver's Legal **First** Name	Driver's **Middle** Name	Suffix (Jr, Sr, 1st,2nd,3rd)

Date of Birth	Montana Driver License Number	Phone Number or Email Address

Montana **Mailing** Address	City	State	Zip Code	New Address?
				☐ Yes ☐ No
Montana **Residential** Address	City	State	Zip Code	New Address?
				☐ Yes ☐ No

INTRODUCTION TO PHYSICIAN:

Montana State Law, MCA 61-5-111(3) (d)(ii), requires a medical evaluation form to be completed by a licensed physician.

Pursuant to Montana State Law, MCA 61-5-207, **REEXAMINATION OR MEDICAL EVALUATION – WHEN REQUIRED**, a Montana driver license may be denied if it is determined that additional medical evaluation or license testing is required.

Please indicate, to the best of your knowledge, if your patient may have any conditions that could affect the safe operation of a motor vehicle. Complete the sections below and return to patient.

1. IMPAIRMENTS THAT ARE PRESENTLY SHOWN BY YOUR PATIENT:

- ☐ Sporadic loss of conscious awareness
- ☐ Impaired motor function
- ☐ Reaction, or impairment due to change in medication or dosage
- ☐ Neurological or neuromuscular disease
- ☐ Diminished concentration
- ☐ Diminished judgment
- ☐ Memory Loss
- ☐ Alzheimer's disease
- ☐ Confusion
- ☐ Other dementia
- ☐ Other metabolic disorder

Comments: _____

2. IS YOUR PATIENT PHYSICALLY AND MENTALLY CAPABLE OF SAFELY OPERATING A MOTOR VEHICLE, IN YOUR OPINION?

☐ Yes ☐ No

If **NO**, please describe: _____

3. DO YOU RECOMMEND ANY DRIVING RESTRICTIONS OR ADAPTIVE EQUIPMENT FOR YOUR PATIENT?

☐ Yes ☐ No

If **YES**, please describe: _____

LICENSED PHYSICIAN/PROVIDER:

Signature:	Name (printed):	Date:
Type of Practice or Medical Specialty: Medical License Number:	Address (include city, state, zip):	Telephone Number: