



Medical Evaluation for Driver License Mail Renewal

Form 2 of 3

ATTN: RNRP P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-1631 • www.doj.mt.gov

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

- | | |
|--|---|
| <input type="checkbox"/> Sporadic loss of conscious awareness | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Impaired motor function | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Reaction, or impairment due to change in medication or dosage | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Neurological or neuromuscular disease | <input type="checkbox"/> Other dementia |
| <input type="checkbox"/> Diminished concentration | <input type="checkbox"/> Other metabolic disorder |
| <input type="checkbox"/> Diminished judgment | |

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:		Address (include city, state, zip):		Telephone Number:	
Medical License Number:					