# Loss of Consciousness Evaluation Form

Mail to: Driver Control Unit, PO Box 55889, Boston, MA 02205-5889
FAX: 857-368-0902 ● mass.gov/rmv

I hereby authorize the physician completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Registry of Motor Vehicles.

Applicant's Signature: _____ Date: _____

**This form must be fully completed by a medical doctor who is licensed to practice in the Commonwealth of Massachusetts. It must be submitted by mail or fax to the Driver Control Unit.**

## A. Patient Information (Please either print clearly or type)

| Last Name | First Name | Middle Name | Suffix |
|---|---|---|---|
| | | | |

| Driver's License # | Date of Birth (MM/DD/YYYY) | |
|---|---|---|
| | | |

Reported Condition

The patient named above has been reported to the Registry as having experienced a "seizure, syncope, or any other type or episode of altered consciousness which may interfere with the safe operation of a motor vehicle." Individuals who have experienced these episodes are required to voluntarily surrender their licenses for a period of **six months.** The Registry may shorten or expand the surrender period, as an individual case may require and as indicated by the physician's recommendations. However, in order to shorten the Commonwealth's six-month policy for Loss of or Altered Consciousness, the physician must ask to waive the policy with explicit reason(s) and provide all information required by this form.

1. Please state the exact date of the most recent episode:_____

2. Please state cause of the episode (type of disorder suffered):

3. Please state the means, if any, by which the condition is controlled, including any medication and dosages:

4. Please state the degree of disability suffered during an episode, including the extent of the episode:

5. Please state, in your professional opinion and to a reasonable degree of medical certainty, the probability of reoccurrence of the episode and specific reasons for your estimate. Include frequency of occurrence of the episode(s):

Patient Name: _____ Last 4 Social: _____

6. Please check one of the following categories.

   I hereby certify that in my professional opinion and to a reasonable degree of medical certainty:

   ☐ The patient named above is medically qualified to operate a motor vehicle safely.

   Do you feel that the patient should undergo a competency road examination prior to regaining his/her driver's license? ..... ☐ Yes ☐ No

   ☐ At this time, I am unable to determine the patient's medical qualification to operate a motor vehicle safely and recommend that their license remain in surrendered status. I recommend that the Registry re-evaluate the patient's license eligibility on _____ (month/year).

   ☐ The patient name above is NOT medically qualified to operate a motor vehicle safely.

7. I have read the Commonwealth's Loss of Consciousness Policy Statement referred to above and ask to waive the six-month loss of license requirement. ..... ☐ Yes ☐ No

   See https://www.mass.gov/service-details/medical-standards-for-passenger-class-d-and-motorcycle-class-m-drivers-licenses

8. If applicable, please check one: I have read the attached police report and am aware of the reported incident involving my patient. ..... ☐ Yes ☐ No ☐ N/A

9. Additional Comments:

## B. Physician Certification

| Physician's Name | National Provider Number (NPI #) | Massachusetts Board of Registration # (if you don't have an NPI #) |
|---|---|---|
| | | |

Address

Street City State ☐☐ Zip Code

**I hereby certify, under the pains and penalties of perjury, that the information I have provided herein is true, accurate, and complete.**

Certifying Physician's Signature: _____ Date: _____