REGISTRY OF MOTOR VEHICLES

Request for Medical Evaluation

Mail to: Medical Affairs, PO Box 55889, Boston, MA 02205-5889
FAX: 857-368-0018 ● mass.gov/rmv

This form is to be completed only by a medical provider or law enforcement official to report a person to be believed no longer physically and/or cognitively capable. Please provide as much information as possible. It must be submitted by mail or fax to Medical Affairs.

A. Driver Information (Required)

Last Name	First Name	Middle Name	Suffix

Driver's License # OR Social Security Number	Date of Birth (MM/DD/YYYY)

Current Address

Street City State Zip Code

Please briefly describe reason for medical concern (Required – failure to answer may result in delays):

Please check <u>one</u> of the following categories:

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

- ☐ The person named above in NOT medically qualified to operate a motor vehicle safely.
- ☐ I am unable to determine driving ability and I recommend the person undergo a competency road examination.
- ☐ The person may require adaptive equipment and/or an assessment for appropriate license restrictions via a competency road examination.

B. Medical Provider or Law Enforcement Official Information

Profession/Title (e.g. Law Enforcement or Health Care Provider)	Place of Employment (e.g. Saugus Police Dept. or Boston Medical Center)
Medical Professionals, please provide National Provider Number (NPI). If you don't have an NPI, please provide Massachusetts Board of Registration Number. Law Enforcement, please provide Badge Number.	Law Enforcement Professionals: Was the driver cited by you? ☐ No ☐ Yes, Citation Number:

Health Care Provider Definition: A registered nurse, licensed practical nurse, physician, physician's assistant, psychologist, occupational therapist, optometrist, ophthalmologist, osteopath, physical therapist, or podiatrist who is a licensed health care provider under the provisions of M.G.L., Chapter 112.

C. Certification

By signing this form, I swear (affirm), under the penalties of perjury, that the information I have provided is true and correct.

Name (Please print): _____ Date: _____

Certifying Signature: _____

Phone: _____