

Request for Medical Evaluation

Medical Affairs • P.O. Box 55889, Boston, MA 02205-5889 Fax: 857-368-0018

This form is used to report a person you believe is no longer physically or medically capable of operating a motor vehicle safely. Please provide as much information as possible.

A. Driver Information (Required)					
Last Name	First Na	ame M	iddle Name	Suffix	
Driver's License # OR Social Security Number			Date of Birth (MM/DD/YYYY)		
Current Address					
Street	City	St	ate Zip Code		
Please briefly describe reason for concern (Re	equired):				
By signing this form, I swear (affirm), under the Signed:			•		
Name (Please print):					
		Ph	ione:		
B. For Law Enforcement or Health	Care Provider	Only (If not law enforceme	nt or a health care provide, leav	re blank)	
Please check one of the following categori	es:				
I hereby certify that in my professional opinion	and to a reasona	ble degree of certainty,			
☐ The person named above in NOT me	dically qualified to	operate a motor vehicle	e safely.		
I am unable to determine driving abilit	y and I recommen	nd the person undergo a	competency road examir	nation.	
The person may require adaptive equipment competency road examination.	ipment and/or an	assessment for appropr	iate license restrictions via	аа	
Please complete applicable areas:					
Signature:			ate		
Name (Please print):		P	hone:		
Profession/Title (e.g. Law Enforcement or Health Care Pr	ovider) Pla	ce of Employment (e.g. Saug	us Police Dept. or Boston Medic	cal Center)	
Medical Professionals, please provide Board of Registrat	on Number Lav	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.

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