State of Maine
Bureau of Motor Vehicles
DRIVER MEDICAL EVALUATION

Merrymeeting Driver Education School
Bath Campus

THIS SECTION TO BE COMPLETED BY DRIVER (Please print)

Name _____ Date of Birth _____

Address _____ License/History Number _____

_____ Telephone _____

TO BE COMPLETED BY APPROPRIATE MEDICAL OR PARAMEDICAL PROFESSIONAL (Clinician)

1. **Reason for Report**: To provide information to the Secretary of State regarding a possible physical, emotional or mental condition which could affect the driver's ability to safely operate a motor vehicle. **Your report will be advisory** and used to assist in determining eligibility for a driver's license.
2. **A Clinician Acting In Good Faith Is Immune** from damages claimed as a result of filing a Driver Medical Evaluation pursuant to 29-A MRSA Section 1258 (6). *The driver's signature is not required to submit this form.*
3. **Please Refer To Functional Ability Profiles (FAP)** to assist you in completing this form. The rules are available at, http://www.maine.gov/sos/bmv/licenses/medical.html. Please **provide Profile Level(s)** for specified condition(s) or any other condition that may affect the driver's ability to safely operate a motor vehicle.
4. **If You Have Any Questions** please call the Bureau of Motor Vehicles, Medical Section, at (207)624-9000, ext. 52124, or access the website; http://www.maine.gov/sos/bmv/licenses/medical.html

DIAGNOSIS THIS SECTION MUST BE COMPLETED – PLEASE PRINT OR TYPE	***FAP PROFILE LEVEL*** CHECK **ONE** BOX PER DIAGNOSIS				
	1	**2**	**3A**	**3B**	**3C**
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

NOTE: If completing for ***Seizures***, ***Stroke***, or other ***Alteration/Loss of Consciousness***, please describe and give date(s) for most recent episode(s)._____

For ***Chronic Pulmonary Disease***, please provide oxygen saturation and indicate if measured while using oxygen or not.
*O2 Saturation*_____ ☐ *Without oxygen* ☐ *On oxygen*

For ***Hypoglycemia requiring 3rd party intervention***, please give date of most recent episode._____
☐ Check here if patient has ***Hypoglycemic Unawareness***.

If completing this form for ***Opioid Replacement Therapy/Prescription Medications*** and patient meets criteria for profile level 3c, please provide sub-category. (3c-i *or* 3c-ii)_____

For ***Substance Abuse*** profile level 3b, please document how long the patient has been substance free._____

CLINICIAN COMMENTS
(Please describe deficits or impairments with potential to affect safe driving. Attach additional documentation, if needed.)

Please proceed to next page…

MEDICATIONS currently prescribed: (may attach med list)

Reliability in taking medications

☐ Good ☐ Fair ☐ Poor ☐ Unknown ☐ No medication prescribed

Has patient reported or demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle? ☐ NO ☐ If yes, please describe_____

CERTIFICATE OF EXAMINATION (May be submitted without the patient signature)

Being duly licensed to practice in the state of _____ I hereby certify that I have examined this applicant.

_____ _____

(Clinician's signature) *(Degree & Specialty)*

_____ _____

(Clinician's name printed or typed) *(Address)*

_____ _____

(Office phone number) *(Office fax number)*

_____ _____

DATE OF LAST EXAM *(Signature Date)*

(Must be within past year or as specified by BMV)

Reply to:

Bureau of Motor Vehicles, Medical Section 29 State House
Station Augusta, Maine 04333-0029
Telephone (207)624-9000 ext. 52124
Please FAX completed form to: 207 624 9319

For assistance or to get a copy of the Functional Ability Profile rules, please go to:

http://www.maine.gov/sos/bmv/licenses/medical.html or call the Medical Section.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical history by _____ to the Secretary of State, Bureau of Motor Vehicles. I understand that this information may be shared with any qualified health care professional submitting information pertaining to the disclosed medical history for the purpose of determining my eligibility for a driver's license.

PATIENT SIGNATURE _____ ***PHONE NUMBER*** _____

DATE _____

Veterans please visit the Bureau of Veterans' Services website at http://www.maine.gov/veterans for information on state and federal benefits your military service may have earned you.