



OFFICE OF THE SECRETARY OF STATE
DRIVER SERVICES DEPARTMENT

DRIVER ANALYSIS DIVISION
2701 S. DIRKSEN PARKWAY
SPRINGFIELD, IL 62723
217-782-7246
www.cyberdriveillinois.com

Medical Report

Pursuant to Section 6-908 of the Driver's License Medical Review Law of 1992 and 625 Illinois Compiled Statutes 5/2-123(j), all medical statements or reports received by the Secretary of State shall be confidential. This information will be disclosed only as authorized by the above referenced statutes as now or hereafter amended.

To be Completed by Individual

(Please print or type)

Pursuant to Section 1030.16 of the Illinois Administrative Code, please complete the following information and sign the medical agreement as a condition of licensure (92 Ill. Adm. Code 1030.16).

Name _____ Driver's License Number _____
Last First Middle
 Street Address _____ Date of Birth _____ Sex Male Female
Mo. Day Year
 City _____ County _____ ZIP Code _____

Agreement

I agree to remain under the care of my physician and follow treatment exactly as prescribed. I also authorize my physician to report any change in my condition that would impair my ability to safely operate a motor vehicle. I understand that failure to abide by the conditions set forth in this agreement are grounds for the Secretary of State to deny or cancel my driving privileges. This report shall remain valid for three months.

 Signature of Individual Date

To be Completed by a Medical Specialist

Medical Condition

1. In your professional opinion, is this individual medically fit to safely operate a motor vehicle? Yes No
2. Does this individual have:

(a) Any Cardiovascular Disease? Yes <input type="radio"/> No <input type="radio"/>	(f) Musculoskeletal Condition? Yes <input type="radio"/> No <input type="radio"/>
(b) Dizzy or Fainting Spells? Yes <input type="radio"/> No <input type="radio"/>	(g) Alcohol/Drug Abuse? Yes <input type="radio"/> No <input type="radio"/>
(c) Seizure Disorder? Yes <input type="radio"/> No <input type="radio"/>	(h) Mental Disorder? Yes <input type="radio"/> No <input type="radio"/>
(d) Other Neurological Disorder? Yes <input type="radio"/> No <input type="radio"/>	(i) Respiratory Condition? Yes <input type="radio"/> No <input type="radio"/>
(e) Diabetes? Yes <input type="radio"/> No <input type="radio"/>	(j) Other _____

(continued on back)

Medical Condition (cont.)

3. List medication(s) prescribed:

4. Under current medical treatment regimen, is condition/disorder controlled? Yes No

5. Have attacks of unconsciousness occurred within the past six months? Yes No

If yes, please provide the date(s) and detail(s):

Mental Disorder

1. In your professional opinion, is this individual mentally fit to safely operate a motor vehicle? Yes No

2. Diagnosis: _____

3. Current Status Controlled/Stable, i.e.,: _____

4. Is Medication/Treatment Prescribed? (Please Specify)

5. Has individual ever been hospitalized for treatment of the noted disorder? Yes No

Last Discharge Date: Month: _____ Year: _____

Comments: _____

Physician's Name (Please Print)

Physician's Address (Please Print)

License Number

Date

Physician's Signature

Telephone Number

Note: Must be signed by licensed medical specialist.