FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES
Medical/Re-Exam Referral Form

This form is completed by examiners/agents to document observations and/or admissions by the customer concerning issues that may affect the customer’s ability to safely operate a motor vehicle.

Customer Information

Name of Customer ________________________________ DOB ________ Sex ________________
Address ________________________________ Telephone Number ________________________________
Driver License Number ________________________________ State ________ Type ________________

Source of Information

A. Driver License Application
   Examiner Name ________________________________ Office Telephone Number ________________________________
B. Informant / Written Complaint
   Name of Informant ________________________________ Relationship to Customer ________________________________
   Address of Informant ________________________________ Telephone Number ________________________________

Observations / Admissions

A. Customer’s Admissions
   ☐ Progressive Neurological Disorder  ☐ Alzheimer’s Disease  ☐ Epilepsy
   ☐ Fainting  ☐ Dizzy Spells  ☐ Alcohol/drug addiction within past 2 years
   Treating Physician Name ________________________________ Telephone Number ________________________________
B. Examiner/Agent Observations
   ☐ Difficulty with Mobility  ☐ Lack of Comprehension or Orientation
   ☐ Hearing or Visual  ☐ Difficulty Responding to Questions Due to Memory or Confusion
   ☐ Violent or Aggressive Behavior  ☐ Weakness or Coordination Problems
   ☐ Other
   Please Explain Any Area That Was Marked: __________________________________________________________
                                                                                                     __________________________________________________________

Recommendation

☐ 5 Day Letter
   o Complete the Five-Day Letter.
   o Retain documents in the issuing office for one year. They do not need to be sent to Medical Review Program.

☐ Forward to Medical
   o Mail or fax the completed form to Division of Motorist Services, Attention: Medical Review Program,
     Room A227, Neil Kirkman Building, Tallahassee, Florida 32399-0570, Fax (850) 617-3944.

Signature of Examiner/Agent  User ID  Date  Signature of Supervisor/Manager  User ID  Date

Office Address  Office Number

HSMV 72419 (Effective 07/18), 15A-5.002, F.A.C.