STATE OF FLORIDA
DEPARTMENT OF HIGHWAY SAFETY
AND MOTOR VEHICLES

Alcohol and Drug Usage Form

Please have this form completed by your physician or treatment provider.

CLIENT/PATIENT’S NAME: _________________________________________ DATE OF BIRTH: ________________

DRIVER LICENSE#: ____________________________ TELEPHONE #: ____________________________________

1. Please provide a brief history of this individual’s alcohol and/or drug usage:
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

2. Has this individual participated in an alcohol/drug treatment program?   Yes ________ No_________
   If yes, please provide the following:
   Where? ________________________________________________________________________________________
   Length of time in treatment: _______________________________________________________________________
   Date of admission/discharge: _______________________________________________________________________ 

3. Is the individual currently participating in an aftercare program?  __________________________________________
   How frequently? ________________________________________________________________________________

4. How long have you known this individual? ___________________________________________________________
   Frequency of contact? _____________________________________________________________________________

5. To the best of your knowledge, how long has this individual been alcohol and/or drug free? 

6. Do you feel this individual would be capable of operating a motor vehicle safely? 
   Yes ________ No____________
   Comments: _____________________________________________________________________________________
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________

Signature: _______________________________________________
Name (please print): ______________________________________
Position/Medical License # (if applicable): ___________________
Address: _____________________________________________
Telephone Number: _____________________________________
Date: __________________________________________________

When Completed, Please Mail to:
Bureau of Motorist Compliance
Medical Review Program
Neil Kirkman Building, MS 86
Tallahassee, Florida 32399-0500
Telephone No.: (850) 617-3814
Fax No.: (850) 617-3944

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