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: _____

   _____

   _____

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

Signature: _____

Name (please print): _____

Position/Medical License # (if applicable): _____

Address: _____

Telephone Number: _____

Date: _____