DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES
Medical Advisory Board Recommendation Form

NAME: _____ DATE: _____

REFERRED TO DOCTOR: _____ BY SPECIALIST: _____

CASE TYPE: ☐ Initial ☐ Follow-up ☐ Re-open ☐ Reconsideration ☐ Administrative Hearing

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☐ CLASS A, B, AND C REVIEW

☐ APPROVAL WITH (check all that apply):

- ☐ NO FOLLOW-UP
- ☐ FOLLOW-UP due to: _____
  _____
  ☐ 3 MONTHS ☐ 6 MONTHS ☐ 1 YEAR ☐ 2 YEARS ☐ OTHER: _____
- ☐ VISION TEST ☐ ROAD TEST ☐ WRITTEN TEST due to: _____
  _____

☐ DENIAL (please indicate below what information can be submitted for reconsideration) due to: _____
_____

☐ DEFER (please indicate below what information is needed)

COMMENTS: _____
_____
_____

☐ CLASS E REVIEW

☐ APPROVAL WITH (check all that apply):

- ☐ NO FOLLOW-UP
- ☐ FOLLOW-UP due to: _____
  _____
  ☐ 3 MONTHS ☐ 6 MONTHS ☐ 1 YEAR ☐ 2 YEARS ☐ OTHER: _____
- ☐ VISION TEST ☐ EXTENDED ROAD TEST ☐ WRITTEN TEST due to: _____
  _____

☐ CERTIFIED DRIVER EVALUATION due to: _____

☐ DENIAL (please indicate below what information can be submitted for reconsideration) due to: _____
_____

☐ DEFER (please indicate below what information is needed)

COMMENTS: _____
_____
_____

_____ _____
Member, Medical Advisory Board Date