# Medical Advisory Board Recommendation Form

**NAME:** ____________________________________________ **DATE:** ________________

**REFERRED TO DOCTOR:** ____________________________ **BY SPECIALIST:** ____________________________

**CASE TYPE:**
- [ ] Initial
- [ ] Follow-up
- [ ] Re-open
- [ ] Reconsideration
- [ ] Administrative Hearing

**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** ____________

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