DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES
MEDICAL REVIEW SECTION
Ignition Interlock Medical Evaluation Form

Name:_____ DOB:_____ Date:_____

Driver License#:_____ Telephone #:_____

Special Note: **This form must be completed by a board eligible/board certified pulmonologist. If you do not have a pulmonary condition, it must be completed by a physician whose specialty relates to your condition.**

Dear Doctor:

This patient has indicated that he/she has a medical condition that interferes with the ability to use an ignition interlock device (IID) as required by law. The IID is a breath alcohol analyzer and is connected to a motor vehicle's ignition. To start the engine, a driver must blow 1.5 liters of air into the device for 5 seconds in a single breath. The engine will not start if an unacceptable level of alcohol is detected. The driver must complete the same procedure at periodic intervals while driving. The standard air volume setting of the IID is 1.5 liters per breath. However, based on the patient's medical condition the setting may be reduced to 1 liter per breath. If the patient is unable to blow into the device at the reduced level, he or she may be eligible for a waiver of this requirement.

1. Current Diagnosis:_____

   Brief history of illness: _____

   Current medications: _____

   Is the patient receiving the best possible treatment for the condition? _____

2. Please provide a copy of a recent pulmonary function test.

3. Based on your medical examination, is the patient capable of breathing into an IID for 5 seconds at the standard air volume setting of **1.5 liters per breath**? Yes __ No __ (**if no, #4 must be completed**)

4. Should the patient be capable of breathing into the IID for a period of 5 seconds if the setting is reduced to **1 liter per breath**? Yes __ No __

   Part A or B **must** be completed:

   A. Please explain your recommendation with reference to the pulmonary function test:_____
   _____
   _____

   B. If you based your recommendation on other (non-pulmonary) medical condition(s)? Please explain in detail:
   _____
   _____

5. Does the patient have any other medical condition(s) that could affect his or her ability to drive safely?
   Yes __ No __ If yes, please explain: _____
   _____

When Completed, Please Mail to:
Bureau of Motorist Compliance
Medical Review Section, MS 86
Neil Kirkman Building
Tallahassee, Florida 32399-0570

Signature of Physician: _____

Print Physician Name: _____

Address: _____

Telephone Number: _____