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Office of the Secretary of State
Driver Services Department

DRIVER ANALYSIS DIVISION
2701 S. DIRKSEN PARKWAY
SPRINGFIELD, IL 62723
217-782-7246
www.cyberdriveillinois.com

Medical Report

Per 625 ILCS 5/6-908 of the Driver's License Medical Review Law and 625 ILCS 5/2-123(j), all medical statements or reports received by the Secretary of State shall be confidential. This information will be disclosed only as authorized by the above-referenced statutes as now or hereafter amended.

SECTION I — To be Completed by Driver (Please print or type)

Pursuant to 92 Illinois Administrative Code 1030.16, please complete the following information and sign the medical agreement as a condition of licensure.

Name _____ Driver's License Number _____
Last First Middle

Street Address _____ Date of Birth _____ Gender ☐ Male ☐ Female
Month Day Year

City _____ ZIP Code _____

Agreement/Release of Information

I agree to remain under the care of my physician and follow the treatment exactly as prescribed. I hereby authorize and request my physician to release information regarding my medical condition to the Illinois Secretary of State, and to report any change in the status of my condition that would impair my ability to safely operate a motor vehicle. I understand that failure to abide by the conditions set forth in this agreement are grounds for the Secretary of State to deny or cancel my driving privileges. ***This report shall remain valid for three months (90 days).***

_____ _____
Signature of Individual Date of Signature

SECTION II MEDICAL HEALTH — To be Completed by MD/DO and/or Medical Professional (NP/PA)

Per Illinois Administrative Code Title 92, Part 1030, all sections of this report must be completed in its entirety.

DATE OF COMPLETION OF MEDICAL HEALTH SECTION II: _____

1. **In your professional opinion, is this individual MEDICALLY FIT to safely operate a motor vehicle?** **YES ☐ NO ☐**
2. Conditions: Yes or No required for each condition listed.
   - (a) Cardiovascular YES ☐ NO ☐ (provide condition)_____
   - (b) Neurological YES ☐ NO ☐ (provide condition)_____
   - (c) Musculoskeletal YES ☐ NO ☐ (provide condition)_____
   - (d) Respiratory YES ☐ NO ☐ (provide condition)_____
   - (e) Seizure YES ☐ NO ☐ (provide condition)_____
   - (f) Diabetes YES ☐ NO ☐
   - (g) Dizzy/Fainting Spell YES ☐ NO ☐
   - (h) Alcohol/Drug Abuse YES ☐ NO ☐
   - (i) Other Medical Condition(s) (provide condition)_____

   ***For mental health disorders, please refer to Section III-Mental Health. Section III must be completed if the individual has a MENTAL HEALTH disorder.**
3. List all current medications prescribed relating to any condition indicated above in Question #2. **(If medications are listed a condition must be disclosed above in Question #2.)** _____
4. ☐ No medications prescribed

(continued on back)

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PATIENT'S NAME: _____

5. Current Status of Condition:
(A) Controlled ☐ (B) Not Controlled: **will not affect driving** ☐ (C) Not Controlled Condition: **may affect driving** ☐
(If Not Controlled is marked, you must provide details, which may include pertinent clinical information, i.e. test results, lab values, etc.)

_____

6. In the past six months, has there been an attack of unconsciousness? YES ☐ NO ☐ Date of Attack _____
(If YES, you must provide details, which may include pertinent clinical information.)

_____

_____

7. Have there been any attack(s) of unconsciousness since the original incident noted in Question 6? YES ☐ NO ☐
Date of Attack(s) _____ **(If YES, you must provide details, which may include pertinent clinical information.)**

_____

_____

8. **If there has been an attack of unconsciousness in the past six months you may provide a recommended time frame to return to driving.** Please explain: _____

_____

_____

SECTION III MENTAL HEALTH — To be completed ONLY if driver has a Mental Health Disorder marked "YES" by MD/DO and/or Medical Professional (NP/PA).

Mental Health Disorder: YES ☐ NO ☐

DATE OF COMPLETION OF MENTAL HEALTH SECTION III: _____

1. **In your professional opinion, is this individual MENTALLY FIT to safely operate a motor vehicle?** **YES ☐ NO ☐**
2. Mental Health Disorder Diagnosis/Condition(s): _____
3. List all current medications prescribed relating to mental health diagnosis/condition indicated above. **(If medications are listed a condition must be disclosed above in Question #2.)** _____

_____

4. ☐ No medications prescribed
5. (A) Controlled ☐ (B) Not Controlled: **will not affect driving** ☐ (C) Not Controlled Condition: **may affect driving** ☐
(If Not Controlled, you must provide details, which may include pertinent clinical information, i.e. test results, lab values, etc.)

_____

SECTION IV — Additional information, special restrictions, etc.

_____

_____

_____

SECTION V — MD/DO and/or Medical Professional (NP/PA)

_____ _____
Name of Medical Provider (Please Print) Medical Provider's Address (Please Print)

_____ ( )_____
Professional License Number/State License Issued Telephone Number

(Unacceptable Signatures: Chiropractors, Residents, Fellows, Interns, RN's, LPN's, Co-signatures)

_____ _____
Provider's Signature — Date of Completion of Medical Health Section ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** Provider's Specialty

_____ _____
Provider's Signature — Date of Completion of Mental Health Section ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** Provider's Specialty

PLEASE MAINTAIN A COPY OF MEDICAL REPORT FOR YOUR RECORDS.