



**State of Maine**  
**Bureau of Motor Vehicles**  
**DRIVER MEDICAL EVALUATION**

Merrymeeting Driver Education  
 207-729-7323  
 tupperc@link75.org

**THIS SECTION TO BE COMPLETED BY DRIVER (Please print)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ License/History Number \_\_\_\_\_  
 \_\_\_\_\_ Telephone \_\_\_\_\_

**TO BE COMPLETED BY APPROPRIATE MEDICAL OR PARAMEDICAL PROFESSIONAL (Clinician)**

- Reason for Report:** To provide information to the Secretary of State regarding a possible physical, emotional or mental condition which could affect the driver's ability to safely operate a motor vehicle. **Your report will be advisory** and used to assist in determining eligibility for a driver's license.
- A Clinician Acting In Good Faith Is Immune** from damages claimed as a result of filing a Driver Medical Evaluation pursuant to 29-A MRSA Section 1258 (6). *The driver's signature is not required to submit this form.*
- Please Refer To Functional Ability Profiles (FAP)** to assist you in completing this form. The rules are available at, <http://www.maine.gov/sos/bmv/licenses/medical.html>. Please **provide Profile Level(s)** for specified condition(s) or any other condition that may affect the driver's ability to safely operate a motor vehicle.
- If You Have Any Questions** please call the Bureau of Motor Vehicles, Medical Section, at (207)624-9000, ext. 52124, or access the website; <http://www.maine.gov/sos/bmv/licenses/medical.html>

**DIAGNOSIS**

THIS SECTION MUST BE COMPLETED – PLEASE PRINT OR TYPE

**FAP PROFILE LEVEL**

CHECK **ONE** BOX PER DIAGNOSIS

	<b>1</b>	<b>2</b>	<b>3A</b>	<b>3B</b>	<b>3C</b>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE:** If completing for **Seizures, Stroke**, or other **Alteration/Loss of Consciousness**, please describe and give date(s) for most recent episode(s). \_\_\_\_\_

For **Chronic Pulmonary Disease**, please provide oxygen saturation and indicate if measured while using oxygen or not.  
 O2 Saturation \_\_\_\_\_  Without oxygen  On oxygen

For **Hypoglycemia requiring 3<sup>rd</sup> party intervention**, please give date of most recent episode. \_\_\_\_\_  
 Check here if patient has **Hypoglycemic Unawareness**.

If completing this form for **Opioid Replacement Therapy/Prescription Medications** and patient meets criteria for profile level 3c, please provide sub-category. (3c-i or 3c-ii) \_\_\_\_\_

For **Substance Abuse** profile level 3b, please document how long the patient has been substance free. \_\_\_\_\_

**CLINICIAN COMMENTS**

*(Please describe deficits or impairments with potential to affect safe driving. Attach additional documentation, if needed.)*

Please proceed to next page...

**MEDICATIONS currently prescribed: (may attach med list)**

**Reliability in taking medications**

Good      Fair      Poor      Unknown                      No medication prescribed

Has patient reported or demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle?      NO                      If yes, please describe \_\_\_\_\_

**CERTIFICATE OF EXAMINATION (May be submitted without the patient signature)**

Being duly licensed to practice in the state of \_\_\_\_\_ I hereby certify that I have examined this applicant.

\_\_\_\_\_  
(Clinician's signature)

\_\_\_\_\_  
(Degree & Specialty)

\_\_\_\_\_  
(Clinician's name printed or typed)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Office phone number)

\_\_\_\_\_  
(Office fax number)

\_\_\_\_\_  
**DATE OF LAST EXAM**  
(Must be within past year or as specified by BMV)

\_\_\_\_\_  
(Signature Date)

**Reply to:**      *Bureau of Motor Vehicles, Medical Section  
29 State House Station  
Augusta, Maine 04333-0029  
Telephone (207)624-9000 ext. 52124  
Fax (207) 624-9319*

**For assistance or to get a copy of the Functional Ability Profile rules, please go to:**  
<http://www.maine.gov/sos/bmv/licenses/medical.html> or call the Medical Section.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize the release of my medical history by \_\_\_\_\_ to the Secretary of State, Bureau of Motor Vehicles. I understand that this information may be shared with any qualified health care professional submitting information pertaining to the disclosed medical history for the purpose of determining my eligibility for a driver's license.

**PATIENT SIGNATURE** \_\_\_\_\_  
**DATE** \_\_\_\_\_

**PHONE NUMBER** \_\_\_\_\_

\_\_\_\_\_  
Veterans please visit the Bureau of Veterans' Services website at <http://www.maine.gov/dvem/bvs> for information on state and federal benefits your military service may have earned you.