INITIAL MEDICAL REQUEST
P-40 REV. 1-2012

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
DRIVER SERVICES DIVISION
ct.gov/dmv

DRIVER'S LICENSE NUMBER

CDL/PS ☐ YES ☐ NO

Address incident of

MAIL TO: DMV, Driver Services Division, 60 State Street, Wethersfield, CT 06161-2510

The patient named below has been referred to the DMV Driver Services Division concerning their ability to safely operate a motor vehicle. This medical report must reflect the results of the medical professional's (licensed physician, PA or APRN) personal examination of the patient performed within 90 days of this report being filed. It must be signed by the patient authorizing the medical professional to release this report and any attachments to DMV.

I hereby authorize the medical professional completing and signing this medical report to release such report to DMV and/or Bureau of Rehabilitative Services (BRS) along with any other medical information necessary to determine my fitness to safely operate a motor vehicle.

PATIENT'S SIGNATURE X

DATE

PATIENT'S NAME *(Please Print)* *(Last)* *(First)* *(Initial)*

DATE OF BIRTH

TELEPHONE NUMBER ( )

PATIENT'S ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

Indicate to the best of your knowledge any and all condition(s) pertaining to this patient.

- ☐ Alcohol/Substance Abuse _____
- ☐ Alzheimer's/Dementia _____
- ☐ Cardiovascular/Hypertension _____
- ☐ Cerebral Palsy _____
- ☐ Cystic Fibrosis _____
- ☐ Endocrine/Glandular _____
- ☐ Liver/Renal Failure _____
- ☐ Narcolepsy _____
- ☐ Neurological/Neuromuscular _____
- ☐ Ophthalmologic _____
- ☐ Orthopedic _____
- ☐ Peripheral Vascular Disease _____
- ☐ Psychiatric/Emotional Disorder _____
- ☐ Pulmonary/Sleep Apnea _____
- ☐ Other _____

HOW LONG HAVE YOU BEEN TREATING THIS PERSON AND FOR WHAT CONDITION(S)?

CONDITION: TREATMENT BEGAN: DATE OF LAST EXAMINATION

IF TREATED BY ANOTHER PHYSICIAN, PLEASE INDICATE NAME, ADDRESS AND SPECIALTY OF PHYSICIAN.

PHYSICIAN'S NAME *(Please Print or Type)* **OFFICE ADDRESS** *(Include Zip Code)*

PHYSICIAN'S SPECIALTY

☐ **This individual has NO medical matters which would affect his/her ability to safely operate a motor vehicle.**

☐ **I do not have sufficient information to determine this person's ability to operate a motor vehicle.**

Considering this patient's condition(s), do you believe this person should be road tested and/or evaluated for special equipment requirements? ☐ YES ☐ NO

MEDICAL PROFESSIONAL CERTIFICATION: I certify that I have personally examined the above named person within the 90 days preceding completion of this report. I swear or affirm under penalty of false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, and subject to penalties for perjury for a deliberate false statement, that the above information and any attachment hereto is true and correct.

MEDICAL PROFESSIONAL'S NAME *(Please Print or Type)*

OFFICE ADDRESS *(Include Zip Code)*

TELEPHONE NUMBER ( )

MEDICAL PROFESSIONAL'S LICENSE NUMBER

MEDICAL PROFESSIONAL'S SPECIALTY

MEDICAL PROFESSIONAL'S SIGNATURE

DATE REPORT COMPLETED