555 Wright Way
Carson City, NV 89711
Reno/Sparks/Carson City (775) 684-4DMV (4368)
Las Vegas Area (702) 486-4DMV (4368)
Rural Nevada or Outside Nevada (877) 368-7828
Fax: (775) 684-4829
Website: www.dmvnv.com

CONFIDENTIAL PHYSICIAN'S REPORT

PLEASE NOTE: According to the Nevada Administrative Code, the Department of Motor Vehicles MUST receive this report within 30 DAYS after the date of the examination.

Driver's License No. ______________________ Date of Birth (MM/DD/YYYY) ____________

Patient's Name ____
Last First Middle

1. Diagnosis: ____

____

2. **In your opinion, will this medical condition affect the patient's ability to drive a vehicle safely?**
☐ Yes* ☐ No ☐ Uncertain* ***If Yes or Uncertain, please explain:***

____

____

3. Status of Patient's Medical Condition(s)*:
☐ Improving ☐ Stable ☐ Worsening or Deteriorating ☐ Subject to Change
**If multiple conditions exist, please describe status and prognosis.*

____

____

4. How long has this person been your patient?

_____ Years _____ Months Date of Last Examination: ____________

5. Is your patient under a controlled medical program? ☐ Yes* ☐ No
If **Yes, how long has control been maintained?* _______ Years _______ Months

6. Is the patient adhering to the medical regimen? ☐ Yes ☐ No*
If **No, please explain:*

____

____

7. Is the patient knowledgeable about the medical condition? ☐ Yes ☐ No

8. Medications prescribed (please list **type** and **dosage**):

____

____

9. **Will these medications affect the patient's ability to operate a motor vehicle safely?**
☐ Yes* ☐ No **If **Yes**, please explain:*

____

____

Please complete BOTH SIDES of this form.

10. Does the nature of the condition indicate loss/lapse of consciousness, seizure activity, fainting or dizzy spells? ☐ Yes* ☐ No
If Yes, please indicate the date** *(MM/DD/YYYY)* **of the last occurrence: ____________

11. Please recommend any restrictions you feel are necessary for this patient to safely drive a vehicle:

____
____
____
____
____

12. Physician's Comments:

____
____
____
____
____
____

____________	____________
Date of Examination	Signature of Attending Physician
Physician's Office Phone Number	Please PRINT Name of Physician

____
Office Address of Physician | City | State and Zip Code

I hereby authorize any physician, surgeon, medical practitioner or other person, and/or any clinic, or hospital, including the Department of Veterans Affairs or government hospital, to release any and all acquired medical information that specifically addresses the information on this form and may relate to, or affect, my ability to operate a motor vehicle safely.

____________ ____________
Patient's Signature | Date

PLEASE NOTE:
According to the *Nevada Administrative Code*, the Department of Motor Vehicles **MUST** receive this report within **30 DAYS** after the date of the examination.