

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.
All fields are MANDATORY

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.

