



A Public Service Agency

REQUEST FOR DRIVER REEXAMINATION

INSTRUCTIONS:

1. Complete this form if you wish the Department of Motor Vehicles (DMV) to reevaluate a driver's ability to drive safely.
2. Sign this request in the signature block provided. Anonymous reports will not be considered unless you are an immediate family member. You may request that your name not be revealed to the individual being reported. Confidentiality will be honored to the fullest extent possible.
3. Take your completed request to any DMV office or mail to: DMV, Driver Safety Office (see addresses below for your local office.)

NAME OF PERSON BEING REPORTED (FIRST, M.I., LAST)		DATE OF BIRTH OR APPROXIMATE AGE	TELEPHONE NUMBER ()
DRIVER LICENSE NUMBER	VEHICLE LICENSE PLATE NUMBER, IF AVAILABLE		
STREET ADDRESS		CITY	STATE ZIP CODE

DRIVER CONDITION—Check all appropriate boxes below. Please use the space below to provide specific details, if known, about the driver's medical (physical or mental) condition such as name of disease or illness, any medications taken, etc.

- | | |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Medical Condition | <input type="checkbox"/> Confused/Disoriented |
| <input type="checkbox"/> Physical Condition | <input type="checkbox"/> Alcohol/Drug Use (Describe below) |
| <input type="checkbox"/> Mental/Emotional Condition | <input type="checkbox"/> Blackouts, Seizures, Fainting Spells |
| <input type="checkbox"/> Vision Condition | <input type="checkbox"/> Needs help with daily activities (i.e., cooking, dressing, bathing, balancing checkbook) |
| <input type="checkbox"/> Weakness or Coordination Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Difficulty Walking | |

DRIVER BEHAVIOR—Check appropriate boxes for driving problems you have observed: (Use space below if needed for additional comments.)

- | | |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Does not see or react to other cars, pedestrians, etc. | <input type="checkbox"/> Turns in front of on-coming cars |
| <input type="checkbox"/> Drives in wrong lane | <input type="checkbox"/> Allows car to drift in and out of lane |
| <input type="checkbox"/> Drives on wrong side of the road | <input type="checkbox"/> Backs up or changes lanes without looking back or checking mirrors |
| <input type="checkbox"/> Acts violent or aggressive when driving | <input type="checkbox"/> Applies brake and gas pedals at the same time |
| <input type="checkbox"/> Drives too slow, or stops, for no reason | <input type="checkbox"/> Slow reactions that may be caused by medications or drugs |
| <input type="checkbox"/> Has trouble steering, braking, or otherwise controlling car | <input type="checkbox"/> Drives on sidewalk |
| <input type="checkbox"/> Is confused by traffic | <input type="checkbox"/> Makes driving mistakes while talking to passengers |
| <input type="checkbox"/> Gets lost or confused while driving near home | <input type="checkbox"/> Falls asleep while driving |
| <input type="checkbox"/> Fails to react to traffic signals, other cars, pedestrians, etc. | <input type="checkbox"/> Other actions (Describe below) |
| <input type="checkbox"/> Makes turns from wrong lane | |

You may use the space below to further describe the driver's condition(s) or action(s) which lead you to believe this driver should be reevaluated by DMV.

YOUR RELATIONSHIP TO DRIVER:

Relative (*Please state exact relationship*): _____

Friend Caregiver Vision Specialist Other: _____

Check here if you would like to have your name kept confidential. Confidentiality will be honored to the fullest extent possible.

NAME (Please print)	DAYTIME TELEPHONE NUMBER ()
---------------------	--------------------------------------

YOUR MAILING ADDRESS (City, State, Zip Code)

SIGNATURE X	DATE
-----------------------	------

YOU MAY MAIL OR TAKE THIS COMPLETED FORM TO YOUR LOCAL DRIVER SAFETY OFFICE AT ONE OF THESE LOCATIONS:

- | | |
|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| City of Commerce , 5801 E. Slauson Ave., Ste. 250
City of Commerce, 90040-3050 | Sacramento , 4700 Broadway, 2nd Flr., Sacramento, 95820-1501 |
| El Segundo , 390 N. Sepulveda Blvd. Ste. 2075, El Segundo, 90245-4470 | San Bernardino , 1845 Business Center Dr., Ste 212,
San Bernardino, 92408-3447 |
| Fresno , 2510 S. East Ave., Ste. 310, Fresno, 93706-5112 | San Diego , 9174 Sky Park Court, Ste. 200, San Diego, 92123-2666 |
| Irvine , 16735 Von Karman Ave., #110, Irvine, 92606-4953 | San Francisco , 1377 Fell St., 2nd Floor, San Francisco, 94117-2296 |
| Oakland , 303 Hegenberger Rd., Ste. 400, Oakland, 94621-1452 | San Jose , 90 Great Oaks Blvd., Ste. 104, San Jose, 95119 |
| Oxnard , 4050 S. Saviers Rd., Oxnard, 93033-6444 | Van Nuys , 6150 Van Nuys Blvd., Ste. 205, Van Nuys, 91401-3333 |