



MEDICAL/EYE REPORT

You may mail this form to DC Department of Motor Vehicles, PO Box 90120, Washington, DC 20090 or fax it to (202) 673-9908.
Visit our website: www.dmv.dc.gov or call 311 or 202-737-4404 for additional information.

This section must be completed by the customer.

LAST NAME		FIRST NAME		MIDDLE NAME	
ADDRESS		APT/UNIT #	CITY	STATE	ZIP CODE
			WASHINGTON	DC	
DATE OF BIRTH (MM/DD/YYYY)	DLN/IDN/SSN	TELEPHONE NUMBER		E-MAIL ADDRESS	

MEDICAL REPORT: This section must be completed by a licensed physician.

Alzheimer <input type="checkbox"/> Yes <input type="checkbox"/> No	*Insulin Dependent Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure or Fainting Spells <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Mental or Physical Conditions <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Medical Report section must be completed by physician and Eye Report section must be completed by Ophthalmologist or Optometrist					
Seizure or fainting spells If yes, when was the last episode? _____ NOTE: Must be seizure free for twelve (12) consecutive months, unless single episode, night time only seizures or due to medication adjustments.			If applicant has a mental or physical condition that would impair his/her ability to drive, please indicate condition:		
Indicate any medical restrictions required:					
Indicate by checking one (1) of the following when the condition should be rechecked by a physician. Seizure disorders require a one year physician examination for five (5) consecutive years					
<input type="checkbox"/> Six (6) months	<input type="checkbox"/> One (1) year	<input type="checkbox"/> Two (2) years	<input type="checkbox"/> Three (3) years	<input type="checkbox"/> Four (4) years	<input type="checkbox"/> N/A

Based on your medical diagnosis, does the applicant have the ability to safely operate a motor vehicle? Yes No

Physician Information:

Physician License Identification Number and State: _____ Telephone No: _____
 Physician Address: _____
 Physician Printed Name: _____
 Physician Signature: _____ Date: _____

EYE REPORT: This section must be completed by a licensed Ophthalmologist or Optometrist.

*Insulin Dependent Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other Eye Disease: _____	Failed DMV Vision Test <input type="checkbox"/> Yes <input type="checkbox"/> No
Vision without Glasses	Vision with Glasses	Field of Vision in horizontal meridian	Indicate by checking one (1) of the following when the condition should be rechecked.	
Right Eye 20/_____ Left Eye 20/_____ Both Eyes 20/_____	Right Eye 20/_____ Left Eye 20/_____ Both Eyes 20/_____		<input type="checkbox"/> Six (6) months <input type="checkbox"/> One (1) year <input type="checkbox"/> Two (2) years	<input type="checkbox"/> Three (3) years <input type="checkbox"/> Four (4) years <input type="checkbox"/> N/A
Minimum Vision Requirements (with or without corrective lenses): No less than 20/40 in the best eye OR no less than 20/70 in the best eye and field of vision at least 140 degrees.			Indicate any vision restrictions required:	

Based on your medical diagnosis, does the applicant have the ability to safely operate a motor vehicle? Yes No

Ophthalmologist or Optometrist Information:

Physician License Identification Number and State: _____ Telephone No: _____
 Physician Address: _____
 Physician Printed Name: _____
 Physician Signature: _____ Date: _____

The making of a false statement on this form is a violation of DC law and subject to a fine of up to \$1,000 or 180 days imprisonment of both. (D.C. Official Code §22-2405)
To report waste, fraud, or abuse by any DC Government Agency or official, call the Office of the DC Inspector General at 1-800-521-1639.