ARIZONA DEPARTMENT OF TRANSPORTATION MOTOR VEHICLE DIVISION

Mail Drop 818Z
Medical Review Program
Motor Vehicle Division
PO Box 2100
Phoenix AZ 85001-2100

Clear

MEDICAL EXAMINATION REPORT

Please read instructions on reverse before completing.

32-4005 R07/25 azdot.gov

Driver Name (first, middle, last, suffix)	Date of Birth	Customer Number	State	Phone ( )

Street Address	City	State	Zip

Symptoms and/or Medical Conditions Reported to MVD (Information reported to MVD is confidential and not subject to release.)

MUST BE COMPLETED BY PATIENT

Medical Information Release – I hereby authorize this physician to release to the Motor Vehicle Division any requested medical information that is pertinent to my ability to safely operate a motor vehicle.

Patient Name (or legal guardian)	Signature	Date

MUST BE COMPLETED BY PHYSICIAN – Examination Date must be within 90 days of the date received by MVD to be accepted.

Examination Date	Diagnosis

Symptoms

Are the symptoms present at all times?	Do you recommend that MVD monitor this person's condition by requiring periodic medical reviews?
❒ Yes ❒ No	❒ Yes (how often?): ❒ No

Current Medications

Do you recommend continuation of driving privilege?
❒ Yes ❒ No (please explain)

Do you recommend any of the following tests?
❒ None ❒ Written ❒ Road/Driving

Complete ONLY for persons with episodes of "altered consciousness".

Date of Most Recent Episode	Describe Type of Episode

Aftereffects of Episodes (i.e., those which could result in fatigue, disorientation or short term inability to function)

Are episodes under control?	Does this person require medication for episodes?
❒ Yes ❒ No (please explain)	❒ Yes ❒ No

Is this person compliant with required medical treatment?
❒ Yes ❒ No (please explain)

The most recent episode:
❒ Was due to deliberate change in anticonvulsant medication ordered by physician. Episode control has since been established with reasonable medical certainty.
❒ Was an isolated occurrence. Another episode is unlikely to occur with reasonable medical certainty.
❒ Occurred only during sleep.
❒ Seizures have an established pattern of an aura of sufficient duration to allow an individual to safely cease operating a motor vehicle upon onset of the aura.

Physician Name (printed)	Physician Signature

Medical License Number ❒ MD ❒ DO	State	Phone ( )

Street Address	City	State	Zip

Driver Instructions

Under the statutory authority below, you are required to have this Medical Examination Report completed by a physician or psychiatrist. The **physician or psychiatrist must mail** the completed report to the Motor Vehicle Division at the address on this form. It must be received within 30 days from the Date of Notice. Failure to do so will result in suspension or revocation of your driving privilege. Should this form be received incomplete, it will be returned to you. This will result in a delay in your evaluation. The physician or psychiatrist must be licensed to practice medicine, osteopathy, homeopathy, optometry or psychiatry in this state, or another state, or employed by the federal government to practice in this state.

You must complete and sign the "Medical Information Release" on this form before giving it to your physician.

The completed form will be evaluated by the Medical Review Program. Based upon the information provided, MVD will make a licensing decision. It is possible that you may be required to submit additional medical information and successfully complete any required testing.

Any driver experiencing any medical condition that affects driving ability is required to report the condition to MVD as soon as the medical condition allows.

Physician Instructions

The driver must have this form completed to be eligible for a driver license. Your response to the questions on this form will indicate to MVD how this person's medical condition affects his or her ability to safely perform the functional skills involved in driving. You must mail the completed report to the Motor Vehicle Division at the address on this form. It must be received within 30 days from the Date of Notice.

Arizona law provides immunity from personal liability to physicians in supplying completed medical forms. It is important that your patient signs the release statement on the top of the form. This gives you the authorization to release pertinent medical information to MVD. State law makes MVD responsible for the licensing decision on individuals.

All sections of the form must be completed. If any of the questions are not applicable to your patient, indicate this in the response section. Incomplete forms will not be accepted and will be returned, which will delay the evaluation.

Authority

Arizona Revised Statutes (ARS) 28-3005, 28-3164, 28-3223, 28-3314; Arizona Administrative Code R17-4-502.