ADOT
Motor Vehicle Division

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

40-1006 R07/13 azdot.gov

MEDICAL REVIEW PROGRAM
SUBSTANCE ABUSE EVALUATION

Clear | Print Blank Form

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

Street Address	City	State	Zip

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

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

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 COUNSELOR, PHYSICIAN OR PSYCHOLOGIST

The driver above is required by state law to have this evaluation completed in order to be considered for driving privileges in Arizona. Your response on this form will indicate to the Motor Vehicle Division how this person's substance abuse condition may affect or impair his or her ability to safely operate a motor vehicle. **We may rely on your opinion for purposes related to the applicant's driving privileges.**

Diagnostic Impressions (DSM IV) – Indicate condition/problem and number of prior contacts. Give facts supporting this diagnosis.

Diagnostic Impressions

Prognosis/Observations/Factors (include reasons for opinion)

Recommendations (**only** if opinion affirmatively indicates an affect upon ability to safely operate a motor vehicle)

Evaluator Certification

This certification must be completed by one of the following:

- Substance abuse counselor who is nationally certified, certified by the Arizona Board of Behavioral Health Examiners, or certified by a comparable board in another state; *or*
- Substance abuse counselor who is employed by the federal government and who is practicing in this state; *or*
- Physician or psychologist who is licensed to practice in this state, or in any other state; *or*
- Physician or psychologist who is employed by the federal government and who is practicing in this state.

Based on my evaluation, it is my opinion that the condition of the Applicant:

❒ **Does** ❒ **Does Not** affect his or her ability to safely operate a motor vehicle.

I certify that I meet one of the above requirements.

Evaluator Name (first, middle, last, suffix)		Title	
Program Name (if applicable)			
Mailing Address	City	State	Zip
Phone ( )	Professional Certification/License Number		
Evaluator Signature	Date		

The **originals** of this form and a **copy of your professional certification/license** must be mailed to the address on this form within 30 days of the signature date, and a copy provided to the Applicant.

Arizona law 28-3005 provides immunity from personal liability to any physician or registered nurse practitioner (for medical conditions) and to any psychologist, physician, psychiatric mental health nurse practitioner or substance abuse counselor (for psychological conditions) 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.