DRIVER CONDITION OR BEHAVIOR REPORT

MV3141 3/2007

The following information is submitted for consideration as "Good Cause" for Departmental action as authorized under section 343.16 Wisconsin Statutes. Advanced age alone, cannot be considered as good cause. **Positive driver identification must be established.** License plate number only is **not** sufficient.

MD, DO or APNP: Please complete back.
All others, complete front.

This information may be subject to Wisconsin's Open Records Law.

Submit to: Wisconsin Department of Transportation
Medical Review
PO Box 7918
Madison, WI 53707-7918

Telephone: 608-266-2327

FAX: 608-267-0518

E-Mail: dre.dmv@dot.state.wi.us

Driver Name – First, Middle, Last	Birth Date	Driver License Number	State of Issuance
Address		City, State ZIP Code	

Driver Condition – Check appropriate boxes. **Describe below.**

- ☐ Physical Condition
- ☐ Mental/Emotional Condition
- ☐ Blackout, Seizure, Fainting Spell
- ☐ Lack of Knowledge of Traffic Laws
- ☐ Confused/Disoriented
- ☐ Alcohol/Other Drugs
- ☐ Defective Vision
- ☐ Obstructing Traffic

Describe in detail incidents or conditions, which brought this driver to your attention. Give specific information such as dates, places, accident reports, all other available information to support the Department's action. Hearsay or second-hand information will not be accepted.

Type of Enforcement Action Taken	Incident Date	Time	Report Date
Title and Signature of Person Completing this Form **X**	Print Full Name		Area Code – Telephone Number
Address – Please Print	City, State ZIP Code		

If this report is being completed by private citizens or family members, the full name, address and signature of a second or additional person who can **verify** the above information is REQUIRED. A signature verifies the information to be true and correct.

Print Name	Area Code – Telephone Number
Address	City, State ZIP Code

(Signature) (Date)

This side must be completed by an MD, DO, or APNP only.

This information is not subject to Wisconsin's Open Records Law; it is, however, available to the driver upon request.

Driver Name – First, Middle, Last	Birth Date	Driver License Number	State of Issuance
Address		City, State ZIP Code	

Describe in detail patient's current medical condition(s) and diagnosis. Give specific information to support the Department's action.

YES	NO		
☐	☐	1.	Is this patient able to safely operate a motor vehicle at this time? A "No" answer will result in immediate cancellation of all license classes and endorsements. The department cannot test a person who is deemed medically unsafe.
☐	☐	2.	If the answer to #1 is yes, do you recommend a complete re-examination of patient's driving ability (knowledge, sign, skills tests)?

Signature of MD, DO or APNP X	Date	Print Full Name	Medical License Number
Mailing Address		City, State ZIP Code	Area Code – Telephone Number