www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

CUSTOMER MEDICAL REPORT

Purpose: Use this form to request medical information from your physician, physician assistant or nurse practitioner.

Instructions: Follow the detailed INSTRUCTIONS printed on page 2. Complete the Customer Information and Information Release Approval sections on this page. Take the entire MED 2 and DMV letter to your physician, physician assistant or nurse practitioner to complete the sections that pertain to your medical condition. Part F must be completed by your physician, physician assistant or nurse practitioner. Note: Any charges related to or incurred as part of the completion of this form are the customer's responsibility.

CUSTOMER INFORMATION

NAME (Last) (First) (MI) (Suffix)			CUSTOMER NUMBER (from your driver's license) or SSN
RESIDENCE/HOME ADDRESS			☐ Check if this is a new address, your address will be changed on DMV's system.
CITY	STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE
MAILING ADDRESS (if different from above)			
CITY	STATE	ZIP CODE	DAYTIME TELEPHONE NUMBER

BIRTH DATE (mm/dd/yyyy)	GENDER ☐ MALE ☐ FEMALE	WEIGHT lbs	HEIGHT FT IN

Describe, in detail, your medical condition.

Do you take prescription/non-prescription medications? ☐ YES ☐ NO If Yes, list below. (attach a separate sheet if more space is required)

NON-PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN	PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN

Have you ever experienced a blackout, seizure, loss of consciousness, or syncope? ☐ YES ☐ NO If Yes, enter date of last episode.	DATE (mm/dd/yyyy)	Did the episode result in a motor vehicle crash? ☐ YES ☐ NO

Explain what happened during the episode.

COMMERCIAL DRIVER LICENSE DISABILITY WAIVER OR HAZARDOUS MATERIALS VARIANCE

Are you applying for a commercial driver license disability waiver or a hazardous materials variance? ☐ YES ☐ NO

If YES, a CDL Disability Waiver or Hazardous Materials Variance Application (MED 30) must also be submitted.

INFORMATION RELEASE APPROVAL

I authorize _____ and/or_____, a licensed medical provider to complete this Customer Medical Report, submit it to DMV and, if necessary to provide further clarification or information to DMV about my physical and/or mental condition. I consent to DMV using this information to arrive at a decision concerning my ability to safely operate a motor vehicle. I also authorize DMV to use the above customer information to correctly identify my records on file in accordance with the Virginia Privacy Protection Act of 1976. I understand that Virginia Code § 46.2-208(b)(1) prohibits DMV from releasing medical data to anyone other than a physician, physician assistant or nurse practitioner

CUSTOMER SIGNATURE AND AUTHORIZATION (parent must sign for a minor)	DATE (mm/dd/yyyy)

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Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

CUSTOMER MEDICAL REPORT
INSTRUCTIONS

Purpose: Use these instructions to complete the Customer Medical Report (MED 2).

CUSTOMER INSTRUCTIONS

1. Review all correspondence received from the Department of Motor Vehicles (DMV) regarding concerns about your ability to safely operate a motor vehicle.
   - If you received an Official Notice/Order of Suspension, you must provide DMV with the required Customer Medical Report, (MED 2) prior to the effective date noted in the Notice/Order to avoid having your driving privilege suspended.
   - If your driving privilege is suspended, you will be required to provide proof of legal presence in order to reinstate your driver's license, if you have not already provided proof.

2. Complete the sections of the MED 2 titled “Customer Information” and “Information Release Approval”. Be sure to provide your signature at the end of the “Information Release Approval” section.

3. Take the entire MED 2 and your DMV letter to your medical provider at the time of your medical examination.

4. Request your medical provider to complete the parts of the MED 2 that pertain to your medical condition(s) and Part F and return the report to DMV (following medical provider instructions below).
   - The medical examination must be conducted after the issue date of your Official Notice/Order of Suspension.
   - If you were involved in a recent motor vehicle crash or have experienced a recent blackout, seizure or loss of consciousness, the MED 2 report must reference these incidents and/or events.

   Note: you will be notified of any decisions regarding your driving privilege based on:
   - Medical and other related information received from your medical provider,
   - DMV driver license test results and/or a certified independent driver rehabilitation evaluation (if required),
   - DMV medical review policies and guidelines as established in collaboration with the DMV Medical Advisory Board.

5. If you have questions related to DMV's requirement for you to submit a MED 2, you may contact DMV Medical Review Services:
   - Mail - send your request in writing to Medical Review Services at the address listed at the top of this form
   - Telephone - (Voice) 1-804-367-6203 or (Deaf/Hearing Impaired only) 1-800-272-9268

MEDICAL PROVIDER INSTRUCTIONS

1. The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
   - level of consciousness/alertness
   - vision/perception
   - motor skills/range of motion
   - judgment/cognitive function
   - reaction time

2. Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s).
   - If your patient was involved in a recent motor vehicle crash or has experienced a recent blackout, seizure or loss of consciousness, the MED 2 report must reference these incidents and/or events.
   - For medical conditions, complete one or more of the following specific report sections:
     - Neurological/Musculoskeletal - Part A & F
     - Metabolic - Part B & F
     - Cardiovascular - Part C & F
     - Pulmonary - Part D & F
     - Psychiatric/Substance Abuse - Part E & F

     NOTE: Only one Part F is required if the same medical provider completes multiple report sections.

3. In lieu of completing the MED 2, you may submit a letter, note or copies of records as long as the information you submit addresses all of the information requested on the MED 2.

4. Return the completed MED 2 to DMV by mailing it to DMV Medical Review Services at the address on the top of this form.

5. For additional information on DMV's medical review process, you may refer to www.dmvnow.com under "Citizen Services", then "Medical Information", or contact Medical Review Services at 804-367-6203.

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN

The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
❍ level of consciousness/alertness ❍ vision/perception ❍ motor skills/range of motion ❍ judgment/cognitive function ❍ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART A - NEUROLOGICAL/ MUSCULOSKELETAL REPORT (must also complete Part F)

Length of time individual has been your patient. YEARS_____ MONTHS_____	Have you examined this individual during the last six months? ☐ YES ☐ NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)

DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? ☐ YES ☐ NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? ☐ YES ☐ NO If Yes, list dates hospitalized and status upon discharge.

Was the hospitalization voluntary? ☐ YES ☐ NO

Does the patient have a history of seizures? ☐ YES ☐ NO If Yes, provide date of each episode and reason(s).

Indicate the risk for further episodes.

Did any seizure result in a motor vehicle crash? ☐ YES ☐ NO If Yes, enter date of crash.	DATE OF CRASH (mm/dd/yyyy)

Was the last medication blood serum level within acceptable range? ☐ YES ☐ NO If No, provide results of blood test.	BLOOD TEST RESULTS

Did the patient have a blackout or syncope? ☐ YES ☐ NO If so, what was the cause? (Please enclose documentation to support the cause; such as results of lab work and blood pressures to support dehydration, high fever, etc.)

Does the patient have any motor deficits/nerve problems that would impair his/her ability to drive? ☐ YES ☐ NO

Does the patient have any other neurological condition(s) that might affect his/her driving? ☐ YES ☐ NO If Yes, describe the condition(s) and its effect on the patient's driving.

Does the patient have any chronic conditions, chronic pain syndromes, fibromyalgia or any movement disorders? ☐ YES ☐ NO If Yes, specify.

Is the patient prescribed medication for chronic pain or long-acting narcotics? ☐ YES ☐ NO If Yes, list the medication(s).

Does the patient have the use of all extremities? ☐ YES ☐ NO If No, which extremities are impaired?

Does the patient suffer from peripheral neuropathy? ☐ YES ☐ NO If Yes, which extremities are impaired?

Current blood levels of anticonvulsant medication	TEST DATE (mm/dd/yyyy)	Results of most recent EEG

Does the neuropathy affect the patient's ability to safely operate a motor vehicle? ☐ YES ☐ NO

Does the patient suffer from muscle spasms? ☐ YES ☐ NO

Does the patient have full range of motion of the head and neck? ☐ YES ☐ NO If No, describe range of motion.

Is adaptive equipment recommended? ☐ YES ☐ NO If Yes, what type of adaptive equipment does the patient require?

Does the patient require a driver evaluation? ☐ YES ☐ NO If Yes, examination should be with: ☐ an independent certified driver rehabilitation specialist (CDRS) ☐ a DMV Examiner ☐ or both.

Go to Part F

Customer Medical Report

NAME (Last) (First) (MI) (Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN

The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
❍ level of consciousness/alertness ❍ vision/perception ❍ motor skills/range of motion ❍ judgment/cognitive function ❍ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART B - METABOLIC REPORT (must also complete Part F)

Length of time individual has been your patient. YEARS_____ MONTHS_____	Have you examined this individual during the last six months? ☐ YES ☐ NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)

DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? ☐ YES ☐ NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? ☐ YES ☐ NO If Yes, list dates hospitalized and status upon discharge.

Was the hospitalization voluntary? ☐ YES ☐ NO

Does the patient have diabetes or any other metabolic condition(s) that might affect vehicle operation? ☐ YES ☐ NO If Yes, indicate condition.

Do any complications or associated conditions exist? ☐ YES ☐ NO If Yes, explain.

Does this patient have hypoglycemic reactions? ☐ YES ☐ NO If Yes, provide dates and reasons.

Did the hypoglycemic reaction(s) result in a motor vehicle crash(es)? ☐ YES ☐ NO

Does this patient demonstrate how to counter a hypoglycemic reaction? ☐ YES ☐ NO If Yes, explain how.

Has this patient been hospitalized for treatment of diabetes/hypoglycemia or complications in the past year? ☐ YES ☐ NO If Yes, explain

Does the patient monitor his/her blood sugar? ☐ YES ☐ NO If Yes, how often?

Attach the following information/documents, If you suffered a hypoglycemic event, please ensure that your blood sugar logs reflect the last 15 days and your A1C results are drawn after the incident occurred and within the last 30 days.

Blood Sugar Logs (15 days) ☐ Attached

Hemoglobin A1C Results (30 days) ☐ Attached

Go to Part F

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN

The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
❍ level of consciousness/alertness ❍ vision/perception ❍ motor skills/range of motion ❍ judgment/cognitive function ❍ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART C - CARDIOVASCULAR REPORT (must also complete Part F)

Length of time individual has been your patient. YEARS_____ MONTHS_____	Have you examined this individual during the last six months? ☐ YES ☐ NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)

DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? ☐ YES ☐ NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? ☐ YES ☐ NO If Yes, list dates hospitalized and status upon discharge.

Was the hospitalization voluntary? ☐ YES ☐ NO

Does the patient have an implantable cardioverter defibrillator? ☐ YES ☐ NO If Yes, give implant date.

Has the unit discharged since the implant? ☐ YES ☐ NO If Yes, describe the patient's condition at the time and date of discharge.

Does the patient have a ventricular assist device system? ☐ YES ☐ NO If Yes, when was this device implanted?

Has the patient had any of the following:

Cardiovascular surgery and/or other procedures? ☐ YES ☐ NO If Yes, explain and give dates.

Syncope? ☐ YES ☐ NO If Yes, explain and give dates.

Attach the following information/documents:
- ☐ Results of Event Monitor
- ☐ Results of Holter Monitor
- ☐ Results of Tilt-table Test
- ☐ Results of EKG

Fatigue with exertion? ☐ YES ☐ NO Fatigue at rest? ☐ YES ☐ NO

Dyspnea with exertion? ☐ YES ☐ NO If Yes, explain and give dates.

Dyspnea at rest? ☐ YES ☐ NO If Yes, explain and give dates.

Pulmonary symptoms? ☐ YES ☐ NO If Yes, explain and give dates.

Go to Part F

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN

The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
❍ level of consciousness/alertness ❍ vision/perception ❍ motor skills/range of motion ❍ judgment/cognitive function ❍ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART D - PULMONARY REPORT (must also complete Part F)

Length of time individual has been your patient. YEARS_____ MONTHS_____	Have you examined this individual during the last six months? ☐ YES ☐ NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)

DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? ☐ YES ☐ NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? ☐ YES ☐ NO If Yes, list dates hospitalized and status upon discharge.

Was the hospitalization voluntary? ☐ YES ☐ NO

Is oxygen use required? ☐ YES ☐ NO If Yes, describe treatment regimen and provide number of liters.

Fatigue with exertion? ☐ YES ☐ NO Fatigue at rest? ☐ YES ☐ NO

Dyspnea with exertion? ☐ YES ☐ NO If Yes, explain and give dates.

Dyspnea at rest? ☐ YES ☐ NO If Yes, explain and give dates.

Syncope from cough? ☐ YES ☐ NO If Yes, explain cause and resolution.

Does the patient have a diagnosis of sleep apnea, narcolepsy, or other sleep disorder? ☐ YES ☐ NO

Does the pulmonary disease prevent activities of daily living? ☐ YES ☐ NO If Yes, identify.

Has patient been compliant with treatment to the extent that the symptoms are controlled? ☐ YES ☐ NO

Attach the following information/documents:
- ☐ Pulse oximetry _____ room air _____ oxygen
- ☐ Results of pulmonary function test
- ☐ Results of sleep study

Go to Part F

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN

The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
❍ level of consciousness/alertness ❍ vision/perception ❍ motor skills/range of motion ❍ judgment/cognitive function ❍ reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART E - PSYCHIATRIC/SUBSTANCE ABUSE REPORT (must also complete Part F)

Length of time individual has been your patient. YEARS_____ MONTHS_____	Have you examined this individual during the last six months? ☐ YES ☐ NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)

DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? ☐ YES ☐ NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? ☐ YES ☐ NO If Yes, list dates hospitalized and status upon discharge.

Was the hospitalization voluntary? ☐ YES ☐ NO

Has the patient been hospitalized in the past year for a mental/emotional condition? ☐ YES ☐ NO If Yes, give admission date(s), reason(s) for admission and date (s) of discharge.

Does the patient have a condition, which results in one or more of the impairments listed below? ☐ YES ☐ NO If Yes, check all that apply.

☐ Poor decision-making/problem-solving skills
☐ Memory loss, Cognitive
☐ Poor impulse control/extremely impulsive
☐ Hallucinations/delusions
☐ Extremely aggressive/destructive behavior
☐ Emotional or behavioral instability
☐ Poor/impaired judgement
☐ Dementia/confusion

Identify current treatment program(s), counseling, medications, etc.

Attach the following information/documents, (if available):
MMSE ☐ attached ☐ not available
Neuropsychological Exam ☐ attached ☐ not available

Is patient CURRENTLY undergoing OR has patient successfully completed drug/alcohol treatment? ☐ YES ☐ NO If Yes, explain.

Did the patient experience seizure(s) related to withdrawal? ☐ YES ☐ NO If Yes, give date(s).

Has the patient been compliant with substance abuse treatment? ☐ YES ☐ NO

Attach the following information/documents:
☐ Results of drug/alcohol screening
☐ Report from substance abuse counselor
☐ Recommendations:

Go to Part F

Customer Medical Report

(MUST BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER)

NAME (Last) (First) (MI) (Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN

PART F - GENERAL RECOMMENDATIONS

FIRST MEDICAL PROVIDER

Is the patient's condition(s) stable? ☐ YES ☐ NO If No, explain.

Is the patient compliant with treatment? ☐ YES ☐ NO If No, explain:

Does the patient experience side effects of medications, which are likely to impair driving ability? ☐ YES ☐ NO If Yes, explain:

Based on this examination, is the patient medically capable of:
- safely operating a motor vehicle? ☐ YES ☐ NO
- safely operating a motorcycle? ☐ YES ☐ NO
- safely operating a commercial motor vehicle includes tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials? ☐ YES ☐ NO

Based on this examination, patient needs the following: (check each appropriate item)
☐ to be retested by DMV on ☐ Knowledge ☐ Road ☐ Both
☐ a driver evaluation (with a certified independent driver rehabilitation specialist CDRS).
☐ an adaptive device/equipment required to safely operate a motor vehicle.
☐ a prosthetic/orthotic device to operate a motor vehicle

For clarification on any of the above, contact Medical Review Services at 804 367-6203.

Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)

Judgment and Insight
☐ Problem Solving and Decision Making ☐ Cognitive Function
☐ Emotional or Behavioral Stability ☐ Reaction Time

Sensorimotor Function
☐ Strength and Endurance ☐ Maneuvering Skills
☐ Range of Motion ☐ Use of Arm(s) and/or Leg(s)

ADDITIONAL RECOMMENDED RESTRICTIONS	MEDICATIONS

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)	MEDICAL SPECIALTY

MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)	ISSUING STATE	TELEPHONE NUMBER ( )	FAX NUMBER ( )

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE	DATE (mm/dd/yyyy)

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.

SECOND MEDICAL PROVIDER

Is the patient's condition(s) stable? ☐ YES ☐ NO If No, explain.

Is the patient compliant with treatment? ☐ YES ☐ NO If No, explain:

Does the patient experience side effects of medications, which are likely to impair driving ability? ☐ YES ☐ NO If Yes, explain:

Based on this examination, is the patient medically capable of:
- safely operating a motor vehicle? ☐ YES ☐ NO
- safely operating a motorcycle? ☐ YES ☐ NO
- safely operating a commercial motor vehicle includes tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials? ☐ YES ☐ NO

Based on this examination, patient needs the following: (check each appropriate item)
☐ to be retested by DMV on ☐ Knowledge ☐ Road ☐ Both
☐ a driver evaluation (with a certified independent driver rehabilitation specialist CDRS).
☐ an adaptive device/equipment required to safely operate a motor vehicle.
☐ a prosthetic/orthotic device to operate a motor vehicle

For clarification on any of the above, contact Medical Review Services at 804 367-6203.

Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)

Judgment and Insight
☐ Problem Solving and Decision Making ☐ Cognitive Function
☐ Emotional or Behavioral Stability ☐ Reaction Time

Sensorimotor Function
☐ Strength and Endurance ☐ Maneuvering Skills
☐ Range of Motion ☐ Use of Arm(s) and/or Leg(s)

ADDITIONAL RECOMMENDED RESTRICTIONS	MEDICATIONS

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)	MEDICAL SPECIALTY

MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)	ISSUING STATE	TELEPHONE NUMBER ( )	FAX NUMBER ( )

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE	DATE (mm/dd/yyyy)

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.