REQUEST FOR DRIVER REVIEW

INSTRUCTIONS:

1) Complete this form if you wish for the Department of Driver Services (DDS) to review a driver's ability to drive safely.
2) Sign and date this request. **Anonymous reports will not be considered**. You may request that your name not be revealed to the individual being reported. Confidentiality will be honored to the fullest extent possible.
3) Mail or fax your completed request to: **Georgia Department of Driver Services**
   c/o Medical Review Unit
   P.O. Box 80447
   Conyers, GA 30013
   Fax to (770) 344-3629

*The driver does not have to be cited. Please indicate evidence of the incapacity in the area below. If the driver was involved in a traffic accident, attach a copy of the report.

SECTION COMPLETION REQUIRED

Name of Person being reported (First, MI, Last) | Date of Birth or Approximate Age | Telephone Number

Driver License Number | Vehicle License Plate Number, if available

Street Address | City | State | Zip Code

DRIVER CONDITION: Check all appropriate boxes below. Please use the space below to provide specific dates, if known, about the driver's medical (physical or mental) condition such as name of disease or illness, any medications taken, etc.

	Medical Condition		Confused/Disoriented
	Physical Condition		Alcohol/Drug Use (Describe below)
	Mental/Emotional Condition		Blackouts/ Fainting Spells
	Vision Condition		Seizures
	Weakness or Coordination Problems		Needs help with daily activities (i.e. cooking, dressing, bathing etc.)
	Difficulty Walking		Other:

DRIVER BEHAVIOR: Check appropriate boxes for driving problems you have observed (Use space below for additional comments as needed).

	Does not see or react to other cars, pedestrians etc.		Turns in front of on-coming cars
	Drives in wrong lane		Allows car to drift in and out of lane
	Drives on wrong side of road		Backs up or changes lanes without looking back or checking mirrors
	Acts violent or aggressive when driving		Applies brake and gas pedals at the same time
	Drives too slow, or stops, for no reason		Slow reactions that may be caused by medication or drugs
	Is confused by traffic		Drives on sidewalk
	Has trouble steering, braking or otherwise controlling car		Makes driving mistakes while talking to passengers
	Gets lost or confused while driving near home		Falls asleep while driving
	Fails to react to traffic signals, other cars, or pedestrians		Other actions (describe below)
	Makes turns from wrong lane		

You may use the space below to further describe the driver's condition(s) or action(s) which led you to believe this driver should be evaluated by DDS. Describe any impairment, serious physical injury or illness, mental impairment or disorientation. Describe any traffic law violations whether or not a citation was issued.

The following section must be completed, including a signature and date in order for DDS to initiate a review.

Your relationship to driver (check one):

_____ Relative (Please state exact relationship): _____

_____ Law Enforcement Officer _____ Physician _____ Caregiver _____ Vision Specialist _____ Other: _____

_____ Check here if you would like to have your name kept confidential. Confidentiality will be honored to the fullest extent possible.

Your Name (Please Print) | Daytime Telephone Number

Your Mailing Address (City, State, Zip Code)

I certify (or declare) under penalty of perjury under the laws of the State of Georgia that the information I have provided is true and correct.

SIGNATURE REQUIRED | **DATE REQUIRED**