



OFFICE OF THE SECRETARY OF STATE
DRIVER SERVICES DEPARTMENT

DRIVER ANALYSIS DIVISION
2701 S. DIRKSEN PARKWAY
SPRINGFIELD, IL 62723
217-782-7246
www.cyberdriveillinois.com

Medical Report

Per 625 ILCS 5/6-908 of the Driver's License Medical Review Law and 625 ILCS 5/2-123(j), all medical statements or reports received by the Secretary of State shall be confidential. This information will be disclosed only as authorized by the above-referenced statutes as now or hereafter amended.

SECTION I To be Completed by Driver (Please print or type)

Pursuant to 92 Illinois Administrative Code 1030.16, please complete the following information and sign the medical agreement as a condition of licensure.

Name _____ Driver's License Number _____
Last First Middle

Street Address _____ Date of Birth _____ Sex Male Female
Month Day Year

City _____ ZIP Code _____

Agreement/Release of Information

*I agree to remain under the care of my physician and follow the treatment exactly as prescribed. I hereby authorize and request my physician to release information regarding my medical condition to the Illinois Secretary of State, and to report any change in the status of my condition that would impair my ability to safely operate a motor vehicle. I understand that failure to abide by the conditions set forth in this agreement are grounds for the Secretary of State to deny or cancel my driving privileges. **This report shall remain valid for three months.***

Signature of Individual

Date

SECTION II (MEDICAL) To be Completed by Medical Specialist

Per Illinois Administrative Code Title 92, Part 1030, all sections of this report must be completed in their entirety.

1. In your professional opinion, is this individual **MEDICALLY FIT** to safely operate a motor vehicle? Yes No

2. Conditions: Must answer Yes or No for each condition below.

- (a) Cardiovascular YES NO (provide condition) _____
- (b) Neurological YES NO (provide condition) _____
- (c) Musculoskeletal YES NO (provide condition) _____
- (d) Respiratory YES NO (provide condition) _____
- (e) Seizure YES NO (provide condition) _____
- (f) Diabetes YES NO
- (g) Dizzy/Fainting Spell YES NO
- (h) Alcohol/Drug Abuse YES NO
- (i) Mental Disorder YES NO (Note: If Mental Disorder indicated, Section III must be completed.)
- (j) Other Medical Condition(s) (provide condition) _____

3. List all current medications prescribed relating to any condition indicated above: _____

4. No medications prescribed

(continued on back)

