



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**

Pursuant to Section 6-908 of the Driver's License Medical Review Law of 1992 and 625 Illinois Compiled Statutes 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.

**To be Completed by Individual**

(Please print or type)

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

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Driver's License Number \_\_\_\_\_  
Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  Male  Female  
Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ ZIP Code \_\_\_\_\_

**Agreement**

*I agree to remain under the care of my physician and follow treatment exactly as prescribed. I also authorize my physician to report any change in 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 \_\_\_\_\_

**To be Completed by a Medical Specialist**

Medical Condition		Medical Opinion	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>1. In your professional opinion, is this individual medically fit to safely operate a motor vehicle?</b>			
2. Does this individual have:			
(a) Any Cardiovascular Disease?	Yes <input type="radio"/> No <input type="radio"/>	(f) Musculoskeletal Condition?	Yes <input type="radio"/> No <input type="radio"/>
(b) Dizzy or Fainting Spells?	Yes <input type="radio"/> No <input type="radio"/>	(g) Alcohol/Drug Abuse?	Yes <input type="radio"/> No <input type="radio"/>
(c) Seizure Disorder?	Yes <input type="radio"/> No <input type="radio"/>	(h) Mental Disorder?	Yes <input type="radio"/> No <input type="radio"/>
(d) Other Neurological Disorder?	Yes <input type="radio"/> No <input type="radio"/>	(i) Respiratory Condition?	Yes <input type="radio"/> No <input type="radio"/>
(e) Diabetes?	Yes <input type="radio"/> No <input type="radio"/>	(j) Other _____	

(continued on back)

**Medical Condition (cont.)**

3. List medication(s) prescribed:

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4. Under current medical treatment regimen, is condition/disorder controlled?      Yes       No

5. In the past six months have there been any attacks of unconsciousness?      Yes       No

If yes, please provide the date(s) and detail(s):

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**This section applies only to Mental Disorder**

Mental Opinion

1. In your professional opinion, is this individual mentally fit to safely operate a motor vehicle?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
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2. Diagnosis: \_\_\_\_\_

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3. Current Status Controlled/Stable, i.e.,: \_\_\_\_\_

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4. Is Medication/Treatment Prescribed? (Please Specify)

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5. Has individual ever been hospitalized for treatment of the noted disorder?      Yes       No

Last Discharge Date:    Month: \_\_\_\_\_    Year: \_\_\_\_\_

Comments: \_\_\_\_\_

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Physician's Name (Please Print)

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Physician's Address (Please Print)

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License Number

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Date

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Physician's Signature

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Telephone Number

**Must be signed by a licensed medical specialist. LPNs, RNs or PAs are unacceptable. No stamped signatures.**