DEPARTMENT OF HIGHWAY SAFETY & MOTOR VEHICLES
MEDICAL REVIEW SECTION
Crash Report Questionnaire

RE: **«FullName»**
DL#: **«DLnumber»**
DOB: **«DOB»**

Dear Doctor:

On **«CrashDate»** this person was involved in a motor vehicle crash in which he/she reportedly had a **«Reason»** while operating a motor vehicle. We are in the process of assessing this individual's ability to safely operate a motor vehicle and need your input on the following questions:

1. How long have you treated this patient? When did you last see the patient in your office?

2. What is the probable cause of the **«Reason»** and what treatment, if any, is the patient currently receiving?

3. Has the patient experienced any similar incidents since the crash? If yes, provide the date(s), as well as, the probable cause of each episode.

4. From a medical standpoint, do you believe that it is safe for the patient to continue to operate a motor vehicle? Yes: _____ No: _____

Additional Comments:_____
_____
_____

Signature of Physician: _____
Print Physician Name: _____
Address:_____
Telephone Number: _____
Date: _____

When Completed, Please Mail to:
Bureau of Motorist Compliance
Medical Review Section, MS 86
Neil Kirkman Building
Tallahassee, Florida 32399-0570

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