Department of Public Safety
DRIVER COMPLIANCE DIVISION

REQUEST FOR DRIVER REVIEW

Please print or type ***✻ areas must be completed.***

I request that the below named individual be reviewed in connection to retaining their driving privileges.

✻ Driver's Name Last	First	Middle	**✻ Date**

✻ Driver License Number	**✻ Mailing Street Address**	**✻ City**	**✻ State**	**✻ Zip**

✻ Based upon my observations of the above named individual, I believe this individual should be reviewed and/or be required, at a minimum, to complete the following:

Medical Examination ☐ Vision Examination ☐ Driver License Written Exam ☐ Driving Skills Exam ☐

✻ Please describe in detail (1) the circumstances that led to this request, (2) your observations of the individual's medical and/or visual condition, and (3) the reason(s) that you believe would prevent this individual from safely operating a motor vehicle. (An example of the behavior indices that the Medical Desk would be looking for include any of the following: disorientation, mental confusion, senility, lapses of attention, behavioral changes, impaired reflexes, impaired balance recovery, orthostatic hypotension, or any condition which would cause loss of control or partial control of a motor vehicle). If necessary, use the back of form or attach pages to supply the information requested immediately above.

✻ If the medical condition has been diagnosed by a physician, please check the appropriate box below:

Amputation(s) ☐ **Visual Loss** ☐ **Psychiatric** ☐ **Dementia** ☐ **Seizures** ☐ **Stroke** ☐
Traumatic Brain Injury ☐ **Parkinson** ☐ **Neurological** ☐ **Paralysis** ☐ **Multiple Sclerosis** ☐

I, the undersigned requestor, hereby certify that I am submitting the Request For Driver Review form in good faith without negligence or malicious intent.

✻ Name of Person requesting Review / Title	**✻ Signature**	**✻ Date**

✻ Address	**✻ City**	**✻ State**	**✻ Zip**

Source of Information: (Judge ☐ Law Enforcement Officer ☐ Licensed Health Care Professional ☐
Private Citizen ☐ Relative of Driver ☐ Other (______________________________)

NOTICE: I understand that by signing and submitting this form, the above referenced individual's ability to operate a motor vehicle may be reviewed by the Department pursuant to 47 O.S. Sections 6-207 and 6-119 and OAC 595:10-5-13.

NOTICE: The Department cannot guarantee that the requestor on this form will remain anonymous throughout any review process which may be initiated as a result of making this request. Further, an emailed copy of this request will NOT be accepted by the Medical Desk because an original signature of the requestor is required to initiate a medical inquiry.

Mail this completed request to:
Department of Public Safety
Driver Compliance Division - Medical Desk
PO Box 11415
Oklahoma City, OK 73136-0415

If you have any questions, please consult the Frequently Asked Questions (FAQs) found on the Department's website at www.ok.gov/dps/ under Driving and Health Issues FAQs or call (405)425-2083 or (405)425-2059