DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES
Medical Advisory Board Recommendation Form

NAME: ____________________ DATE: ____________

REFERRED TO DOCTOR: ____________________ BY SPECIALIST: ____________

CASE TYPE: ☐ Initial ☐ Follow-up ☐ Re-open ☐ Reconsideration ☐ Administrative Hearing

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☐ CLASS A, B, AND C REVIEW

☐ APPROVAL WITH (check all that apply):

- ☐ NO FOLLOW-UP
- ☐ FOLLOW-UP due to: ____________________
  - ☐ 3 MONTHS ☐ 6 MONTHS ☐ 1 YEAR ☐ 2 YEARS ☐ OTHER: ____________
- ☐ VISION TEST ☐ ROAD TEST ☐ WRITTEN TEST due to: ____________________

☐ DENIAL (please indicate below what information can be submitted for reconsideration) due to: ____________

☐ DEFER (please indicate below what information is needed)

COMMENTS: ____________________

☐ CLASS E REVIEW

☐ APPROVAL WITH (check all that apply):

- ☐ NO FOLLOW-UP
- ☐ FOLLOW-UP due to: ____________________
  - ☐ 3 MONTHS ☐ 6 MONTHS ☐ 1 YEAR ☐ 2 YEARS ☐ OTHER: ____________
- ☐ VISION TEST ☐ EXTENDED ROAD TEST ☐ WRITTEN TEST due to: ____________________

☐ CERTIFIED DRIVER EVALUATION due to: ____________________

☐ DENIAL (please indicate below what information can be submitted for reconsideration) due to: ____________

☐ DEFER (please indicate below what information is needed)

COMMENTS: ____________________

____________________ Member, Medical Advisory Board

____________ Date