State of Arkansas

Department of Finance and Administration

Medical Evaluation Request

The Office of Driver Services, having good cause to believe that a licensed driver is incompetent or otherwise not qualified to be licensed may require the licensee to submit to an initial evaluation by a Driver Control Hearing Officer.

Law Enforcement, Medical Professionals, Motor Vehicle Administrations and concerned relative may report drivers who they think are no longer able to safely operate a motor vehicle.

Completed forms can be submitted in the following ways:

By Mail:
Driver Control
P.O. Box 1272 Room 1070
Little Rock, AR 72203

By Fax:
(501) 683-0955

Email:
arhearingofficers@dfa.arkansas.gov

Important Information about Initial Evaluations:

- Please be as specific as possible about the medical, vision and mental conditions of the driver and include all supporting documents possible.
- All information submitted must be of personal knowledge or observation.
- **The age of the driver will not be taken into consideration**. **Referrals must only be made in the interest of public safety and not due to age alone.**
- Based on the information provided, the driver may be required to have a medical evaluation and/or retake all or part of the driver's license exam.
- The final determination **will not** be released to the person submitting the referral form.
- **Immediate family members that request an evaluation will be required to attend the initial evaluation.**
- Anonymous requests will not be accepted.

SECTION 1– DRIVER'S PERSONAL INFORMATION			
NAME (FIRST AND LAST)		DRIVER'S LICENSE NUMBER	
DATE OF BIRTH	TELEPHONE NUMBER		
ADDRESS	CITY	STATE	ZIP CODE

SECTION 2– DRIVER BEHAVIOR

- ☐ Traffic Violations
- ☐ Lack of Attention
- ☐ Dangerous Actions
- ☐ Poor Driving Skills
- ☐ Accidents
- ☐ Lack of Knowledge of Traffic Laws

LOCATION	
DATE	TIME

OTHER

_____

_____

ADDITIONAL INFORMATION REGARDING THE DRIVER'S BEHAVIOR

SECTION 3– DRIVER'S MEDICAL CONDITIONS THAT COULD AFFECT DRIVING

SELECT ALL THAT APPLY

☐	Seizure, Convulsions or Epilepsy	☐	Mental Illness
☐	Head, Neck, Spinal Injury or Disorder	☐	Permanent Impairment
☐	Vision Disorder	☐	Parkinson's Disease
☐	Heart Attack, Stroke or Paralysis	☐	Neurological Disorder
☐	Lung Disease	☐	Spastic or Paralyzed Muscles
☐	Diabetes or High Blood Sugar	☐	Dementia
☐	Drug or Alcohol Abuse	☐	Taking Medications

PLEASE PROVIDE ADDITIONAL INFORMATION REGARDING MEDICAL CONDITIONS THAT COULD AFFECT THE LICENSEE'S ABILITY TO DRIVE

SECTION 4– REQUESTOR'S INFORMATION

Under penalties of perjury, I declare that the above information and any attached supplement is true, complete and correct. Based solely on my observation(s) of the above-named driver and information relayed to me by the individual, I reasonably and in good faith, believe that they cannot safely operate a motor vehicle. **I understand that I will be informed of by mail of the date, time and location of the initial evaluation and I am required to attend.**

SIGNATURE OF REQUESTOR			
NAME (FIRST AND LAST)		DRIVER'S LICENSE NUMBER	
DATE OF BIRTH	TELEPHONE NUMBER		
ADDRESS	CITY	STATE	ZIP CODE