



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:	By Fax:	Email:
Driver Control	(501) 683-0955	arhearingofficers@dfa.arkansas.gov
P.O. Box 1272 Room 1070		
Little Rock, AR 72203		

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											
<input type="checkbox"/> Traffic Violations <input type="checkbox"/> Lack of Attention <input type="checkbox"/> Dangerous Actions <input type="checkbox"/> Poor Driving Skills <input type="checkbox"/> Accidents <input type="checkbox"/> Lack of Knowledge of Traffic Laws	<table border="1"> <tr> <td colspan="2">LOCATION</td> </tr> <tr> <td>DATE</td> <td>TIME</td> </tr> <tr> <td colspan="2">OTHER</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td colspan="2">_____</td> </tr> </table>	LOCATION		DATE	TIME	OTHER		_____		_____	
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			
<input type="checkbox"/>	Seizure, Convulsions or Epilepsy	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Head, Neck, Spinal Injury or Disorder	<input type="checkbox"/>	Permanent Impairment
<input type="checkbox"/>	Vision Disorder	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Heart Attack, Stroke or Paralysis	<input type="checkbox"/>	Neurological Disorder
<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Spastic or Paralyzed Muscles
<input type="checkbox"/>	Diabetes or High Blood Sugar	<input type="checkbox"/>	Dementia
<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	Taking Medications

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

SECTION 4- REQUESTOR'S INFORMATION			
<p>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.</p>			
SIGNATURE OF REQUESTOR			
NAME (FIRST AND LAST)			DRIVER'S LICENSE NUMBER
DATE OF BIRTH	TELEPHONE NUMBER		
ADDRESS	CITY	STATE	ZIP CODE