DRIVER EVALUATION REQUEST

DMV may require re-evaluation only when there is reason to believe that a driver may no longer be qualified to hold a license. The individual may be required to take vision, knowledge or driving tests or obtain a medical clearance.

INSTRUCTIONS:
1. Complete this form to request that DMV re-evaluate a driver’s ability to drive safely.
2. Sign this request in the signature block provided. **Anonymous requests will not be honored.**
3. Mail or fax completed request to: DMV, Driver Safety Unit, 1905 Lana Avenue NE, Salem Oregon 97314; FAX: (503) 945-5329.

### NAME OF PERSON TO BE RE-EVALUATED

<table>
<thead>
<tr>
<th>(Last, First, Middle)</th>
<th>SEX (Circle)</th>
<th>ODL / CUSTOMER NUMBER</th>
<th>DATE OF BIRTH</th>
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<tr>
<th>STREET ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
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</table>

### DRIVER BEHAVIOR – Check appropriate boxes for driving problems you have observed:

- ☐ Does not see or react to other cars, pedestrians, etc.
- ☐ Drives in wrong lane or on wrong side of road
- ☐ Allows car to drift in and out of lane
- ☐ Drives on sidewalk
- ☐ Makes turns from wrong lane
- ☐ Turns in front of on-coming cars
- ☐ Acts violently or aggressively when driving
- ☐ Drives too slowly, or stops, for no reason
- ☐ Has trouble steering, braking, or otherwise controlling car
- ☐ Applies brake and gas pedals at the same time
- ☐ Is confused by traffic
- ☐ Gets lost or confused while driving near home
- ☐ Backs up or changes lanes without looking back or checking mirrors
- ☐ Fails to react to traffic signals, other cars, pedestrians, etc.
- ☐ Has slow reaction times (caused by medications, drugs or condition)
- ☐ Makes driving mistakes while talking to passengers
- ☐ Falls asleep while driving
- ☐ Other actions (describe below)

Please use the space below and the back of this form to provide **specific information such as events, dates and places** which cause you to question the individual’s ability to drive safely. If you believe the person has a medical condition/impairment that impacts safe driving, please provide information about its impact on their ability to safely operate a motor vehicle. Attach any supporting documentation.

### REQUESTS BASED ON AGE, DIAGNOSIS AND/OR GENERAL HEALTH ALONE WILL NOT BE HONORED.

☐ Check here if you want your name kept confidential. DMV may not be able to keep this request confidential if the driver requests a hearing or files a lawsuit against DMV.

**YOUR RELATIONSHIP TO THE DRIVER:**

- ☐ Law Enforcement
- ☐ Physician*
- ☐ Health Care Provider* (explain): ____________________________
- ☐ Relative
- ☐ Friend
- ☐ DMV Employee
- ☐ Court
- ☐ Other (explain): ____________________________

* Medical providers who are required to report patients under the mandatory reporting program must use DMV Form 735-7230. Please refer to www.OregonDMV.com for more information.

### SECTION FOR LAW ENFORCEMENT AGENCY OR COURT ONLY

Request is a result of:
- ☐ Traffic Accident (attach report)
- ☐ Traffic Stop
- ☐ Date of Incident: ____________________________

Was the driver issued a traffic citation?
- ☐ YES
- ☐ NO
- ☐ Citation for: ____________________________

Is this request submitted instead of a citation?
- ☐ YES
- ☐ NO
- ☐ Officer’s Title: ____________________________

**Agency name:** ____________________________

**Agency Phone:** ____________________________

735-6066 (7-17)

SYK# 3002290