DEPARTMENT OF TRANSPORTATION
DRIVER AND MOTOR VEHICLE SERVICES
1905 LANA AVE NE, SALEM OREGON 97314

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 (Last, First, Middle)	**SEX** (Circle) M F X	**ODL / CUSTOMER NUMBER**	**DATE OF BIRTH**	
STREET ADDRESS	**CITY**		**STATE**	**ZIP CODE**

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.*

YOUR NAME (Please Print)	**SIGNATURE** X		**DATE**
YOUR MAILING ADDRESS (City, State, Zip Code)	**DAYTIME TELEPHONE NUMBER**	**FAX**	

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: ______________________