DL-123 (4-12)

GENERAL MEDICAL FORM

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

pennsylvania
DEPARTMENT OF TRANSPORTATION

Bureau of Driver Licensing
P.O. Box 68682
Harrisburg, PA 17106-8682
(717) 787-9662

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12
Provider: For more information relating to Medical Reporting, visit http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml.

PATIENT INFORMATION (Please complete this form in its entirety)

DRIVER'S LICENSE NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT FEET	HEIGHT INCHES	SEX	EYE COLOR	DATE OF BIRTH MONTH	DAY	YEAR	TELEPHONE NUMBER	E-MAIL (if applicable)

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.	CITY	STATE	ZIP CODE

1. How long have you been treating the patient? _____

2. With what diseases/conditions/disorders has the patient been diagnosed? _____

   _____

3. Do the diseases/conditions/disorders interfere with the patient's mental or physical ability to operate a motor vehicle?

   _____

4. Discuss the nature, extent, frequency and control of the relevant symptoms. _____

   _____

   _____

5. Is the patient being treated with medication? _____

   If yes, type: _____ dosage: _____

   If yes, does the medication make him/her unsafe to drive? . . . . . ❑ YES ❑ NO

6. Is the patient receiving any other types of treatment that affects his/her ability to drive? _____

   If yes, please describe: _____

HEALTH CARE PROVIDER INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ _____
Health Care Provider's Signature Date