



Department of Public Safety  
Medical Standards Section

### Request for Driver Review

I believe the below-named individual can no longer safely operate a motor vehicle and I am requesting he or she provide evidence to the Department of Public Safety to the contrary.

#### Driver Information

|                       |            |             |
|-----------------------|------------|-------------|
| Last Name             | First Name | Middle Name |
| Mailing Address       |            |             |
| City                  | ST         | Zip         |
| Date of Birth         |            |             |
| Driver License Number |            |             |

**Based upon my observations of the above-named individual, I believe this individual should be reviewed and/or be required, at a minimum, to complete the following:**

\_\_\_\_\_ Medical Examination      \_\_\_\_\_ Vision Examination  
\_\_\_\_\_ Driver License Written Exam      \_\_\_\_\_ Driving Skills Exam

Please describe in detail the circumstances that led to this request, your observations of the person's **medical and/or visual condition**, and the reason or reasons you believe would prevent this person from safely operating a motor vehicle. (Please use the back of this form or additional pages, if necessary.)

**If the medical condition has been diagnosed by a physician, please check the appropriate diagnosis.**

\_\_\_ Paralysis      \_\_\_ Multiple Sclerosis      \_\_\_ Traumatic Brain Injury      \_\_\_ Amputation(s)      \_\_\_ Visual Loss  
\_\_\_ Psychiatric      \_\_\_ Seizures      \_\_\_ Stroke      \_\_\_ Parkinson      \_\_\_ Dementia  
\_\_\_ Neurological

#### Reporting Party's Information

I am a  
\_\_\_ Law Enforcement Officer    \_\_\_ Licensed Health Care Professional    \_\_\_ Judge    \_\_\_ Private Citizen    \_\_\_ Relative of Driver  
\_\_\_ Other \_\_\_\_\_

|                 |    |     |
|-----------------|----|-----|
| Full Name       |    |     |
| Mailing Address |    |     |
| City            | ST | Zip |

**Notice:** I understand that by signing and submitting this form, the above-referenced individual's ability to operate a motor vehicle may be reviewed by the Department pursuant to 47 O.S. §§ 6-207 and 6-119, and OAC 260:135-5-7.

**Notice:** The Department cannot guarantee that the Reporting Party will remain anonymous throughout any review process which may be initiated as a result of making this request.

\_\_\_\_\_  
Reporting Party Signature

\_\_\_\_\_  
Date

Mail the completed form to:  
Medical Standards Section  
Department of Public Safety PO  
Box 53004  
Oklahoma City, OK 73152-9998

If you have any questions, you may email the Medical Standards Section of the Department of Public Safety at [medicaldesk@dps.ok.gov](mailto:medicaldesk@dps.ok.gov). Please allow 2 business days for a response. You may also call the Medical Standards Section at 405-425-2148.