Medical Affairs
Registry of Motor Vehicles
P.O. Box 55889
Boston, MA 02205-5889

massDOT
Massachusetts Department of Transportation
Registry of Motor Vehicles

LOSS OF CONSCIOUSNESS EVALUATION FORM

I hereby authorize the physician completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Registry of Motor Vehicles.

_____ _____
Applicant's Signature Date

THIS FORM MUST BE FULLY COMPLETED BY A MEDICAL DOCTOR LICENSED TO PRACTICE IN THE COMMONWEALTH OF MASSACHUSETTS.

PATIENT INFORMATION:

Name _____ D.O.B. _____

License #: _____ Reported Condition: _____

The patient named above has been reported to the Registry as having experienced a "seizure, syncope, or any other type or episode of altered consciousness which may interfere with the safe operation of a motor vehicle." Individuals who have experienced these episodes are required to voluntarily surrender their licenses for a period of **six months**. The Registry may shorten or expand the surrender period, as an individual case may require and as indicated by the physician's recommendations. However, in order to shorten the Commonwealth's six month policy for Loss of or Altered Consciousness, the physician must ask to waive the policy with explicit reason(s) and provide all information required by this form.

(1) Please state the exact date of the most recent episode _____

_____

_____

(2) Please state cause of the episode (type of disorder suffered) _____

_____

_____

(3) Please state the means, if any, by which the condition is controlled, including any medications used and dosages

_____

_____

(4) Please state the degree of disability suffered during an episode, including the extent of the episode

_____

_____

(5) Please state, in your professional opinion and to a reasonable degree of medical certainty, the probability of reoccurrence of the episode and specific reasons for your estimate (include frequency of occurrence of the episode(s))

_____

_____

Applicant's Name/Patient's Name: _____

(6) Please check one of the following categories.
I hereby certify that in my professional opinion and to a reasonable degree of medical certainty:

☐ The patient named above is medically qualified to operate a motor vehicle safely.

Do you feel that the patient should undergo a competency road examination prior to regaining their driver's license?

☐ Yes ☐ No

☐ At this time, I am unable to determine the patient's medical qualification to operate a motor vehicle safely and recommend that their license remain in surrendered status. I recommend that the Registry re-evaluate the patient's license eligibility on _____ (month/year).

☐ The patient named above is NOT medically qualified to operate a motor vehicle safely.

(7) I have read the Commonwealth's Loss of Consciousness Policy Statement referred to above and ask to waive the six month loss of license requirement. ☐

See http://www.massrmv.com/Portals/30/docs/lossofco.pdf

(8) If applicable, please check one: I have read the attached police report and am aware of the reported incident involving my patient.

☐ Yes ☐ No ☐ N/A

(9) Additional Comments _____

_____

_____

_____

_____

_____

_____

_____

Physician Certification

I hereby certify, under the pains and penalties of perjury, that the information I have provided herein is true, accurate and complete.

Please print:

_____

Physician's Name — Massachusetts Board of Registration Number (*required*)

_____

Address (City/Town/State/Zip Code)

_____

Certifying Physician's Signature — Date