



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:

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