Form MV346

Medical Report of Physician's Findings

To ensure the safety of all individuals, customers should self-report any changes in their health that might affect their ability to drive.

NAME: ______________________ DATE OF BIRTH: ____________ LICENSE # ____________

ADDRESS: ____

MEDICAL HISTORY

	Yes	No	Not Assessed
NEUROPSYCHOLOGICAL: Is there any evidence of a psychological ptoblem or cognitive impairment (such as dementia) which may affect driving?			
NEUROLOGICAL: Are there any transient neurological problems (such as spells of mental clouding, seizures, convulsions, transient ischemic attacks, or vertigo) or more unchanging problems (such as stroke, traumatic brain injury, or Parkinson's Disease) which may impair driving?			
ORTHOPEDIC AND MUSCULAR: Are there any problems with bones, joints, or muscle weakness, (such as impairment of a hand or foot) which may affect driving?			
Is the use of adaptive equipment required to safely operate a motor vehicle?			
PULMONARY/ CARDIOVASCULAR: Are there any problems with the lungs or heart which may affect driving (such as shortness of breath, fatigue, syncope, or other arrhythmias?)			
ENDOCRINE-DIABETES: Are there any symptoms which may affect driving, (such as episodes of confusion, loss of consciousness or vision changes?)			
VISION/ HEARING: Do you think vision or hearing may be too impaired to drive safely?			
DRUGS AND/OR ALCOHOL: Does the customer describe a problem with addiction, habituation, or alcoholism? If so, is there documented evidence of these problems which may prevent safe driving?			
OTHER MEDICAL: Does the customer suffer from any other condition or disease which may decrease their ability to safely operate a motor vehicle?			

If YES, to any of the above, please explain with a diagnosis, and a date of the most recent episode

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	Yes	No
MEDICATIONS: Is the customer prescribed medications which may affect their ability to drive? If YES, list medications below		

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As of August 2024, DMV no longer requires mandatory reporting of medical conditions. Licensed practitioners are encouraged to report patients who may pose a danger driving.

NAME: ______________________ DATE OF BIRTH: ____________ LICENSE # ____________

RECOMMENDATIONS:

YES, THE CUSTOMER SHOULD BE ALLOWED TO DRIVE (check either 1 or 2)

- ○ 1. I am a **physician**, and I certify that the loss of consciousness episode(s) is under sufficient control and the customer does not have an elevated risk to safely operate a motor vehicle.
- ○ 2. I am a **non-physician licensed practitioner**, and I certify the driver has not had a loss of consciousness episode(s) in the last three months and does not have an elevated risk to safely operate a motor vehicle.

IF YES, MARK ONE OF THE FOLLOWING

- ○ 1. Medical treatment for this condition is ongoing and should be followed by the DMV.
- ○ 2. There is no need for further medical evaluation or for the DMV to follow this condition.

NO, THE CUSTOMER SHOULD NOT BE ALLOWED TO DRIVE

- ○ **NO**, I believe the customer **SHOULD NOT** be permitted to drive. If appropriate, patient can be re-evaluated at a future time for the reinstatement of the license. Please explain your reasoning. (For example, it is too soon after a loss of awareness event). Test results can be included.

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	Yes	No
Do you believe the customer's license suspension should be effective immediately?	○	○
Are you requesting a re-exam?	○	○
If requesting a re-exam, is the customer permitted to drive until re-exam is scheduled?	○	○

LICENSED PRACTITIONER ATTESTATION:

How long have you been treating this patient? ____________ Date of last exam: ____________

Additional comments or if there should be further evaluation from a different licensed practitioner:

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Licensed Practitioner (name printed or typed): ______________________

Signature: ______________________

License number: ______________________

Date: ______________________

Address: ______________________

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Phone Number: ______________________

Fax Number: ______________________

○ I am an emergency, urgent care or inpatient physician. Follow up will be completed by the customer's licensed practitioner.

Please mail the form to:
DMV – Medical Section
PO Box 698
Dover, DE 19903-0698

To transmit electronically:
Fax: (302) 739-5667
Email: DMVmedicalsection@delaware.gov
Attention: **Medical Records Section**