PHYSICIAN'S CERTIFICATE OF MEDICAL IMPAIRMENT

State Form 50018 (R2 / 12-11)
BUREAU OF MOTOR VEHICLES

INSTRUCTIONS:
1. *Complete in blue or black ink.*
2. *Form must be completed by a physician.*
3. *Form must be dated within thirty (30) days of application.*
4. *Section 1 or 2 must be completed by physician.*
5. *Patient/Driver must complete and sign Section 3.*

A copy of this certificate must be carried in any vehicle that this individual operates when a Restriction 8 is displayed on the driver's license or permit.

Section 1 Medical Certification for BMV to Apply Medical Impairment Restriction (Restriction 8)

I, _____ am a licensed physician and I certify and attest
(Physician's Printed Name)
that the individual named below has an existing medical condition that:

☐ Causes him or her to have fainting spells or seizures but is under medication and is free from fainting spells or seizures. (IC 9-24-2-3, IC 9-24-9-2 and IC 9-24-11-7)

☐ Has an existing medical condition which may cause him or her to appear to be intoxicated. (IC 9-24-11-9)

Signature of Physician	Medical License Number	Date (*mm/dd/yyyy*)

Section 2 Medical Certification for BMV to Remove Medical Impairment Restriction (Restriction 8)

I, _____ am a licensed physician and I certify and attest
(Physician's Printed Name)
that the following named individual **no longer** has an existing medical condition that:

☐ Causes him or her to be subject to fainting spells or seizures.

☐ Causes him or her to appear to be intoxicated.

Signature of Physician	Medical License Number	Date (*mm/dd/yyyy*)

Section 3 Patient / Driver Acknowledgment

I understand that a Restriction 8 Medical Impairment Restriction will be:

☐ Applied to my driver's license or permit.

☐ Removed from my driver's license or permit.

I swear or affirm that the information contained herein is true and correct. I understand that making a false statement on this certificate may constitute the crime of perjury.

Printed Name of Patient / Driver	Indiana Driver's License Number	Date (*mm/dd/yyyy*)

Signature of Patient / Driver	Date of Birth (*mm/dd/yyyy*)