Reset Form

PHYSICIAN'S CERTIFICATE OF MEDICAL IMPAIRMENT

State Form 50018 (R4 / 11-24)
BUREAU OF MOTOR VEHICLES

The legal authority for this form is IC 9-24-11-7.

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. The patient/driver must complete Section 1.
5. A physician must complete Section 2 or 3 as applicable.

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 – PATIENT/DRIVER INFORMATION		
Name of Patient/Driver *(last, first, middle initial)*	Indiana Driver's License Number	Date of Birth (*mm/dd/yyyy*)

SECTION 2 – MEDICAL CERTIFICATION FOR BMV TO APPLY MEDICAL IMPAIRMENT RESTRICTION (RESTRICTION 8)

I,

(Physician's Printed Name)

am a licensed physician and I certify and attest that the individual named above 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 3 – MEDICAL CERTIFICATION FOR BMV TO REMOVE MEDICAL IMPAIRMENT RESTRICTION (RESTRICTION 8)

I,

(Physician's Printed Name)

am a licensed physician and I certify and attest that the individual named above **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*)