



REQUEST FOR DRIVING ABILITY REVIEW

State Form 54750 (R2 / 11-24)
INDIANA BUREAU OF MOTOR VEHICLES

The legal authority for this form is IC 9-24-10-6 and IC 9-24-10-7.

BUREAU OF MOTOR VEHICLES
Attn: Driver Ability Department
100 North Senate Avenue
Room N481
Indianapolis, IN 46204
Fax: 317-974-1614

- INSTRUCTIONS:**
1. Complete in blue or black ink.
 2. Completed form must be submitted to the address above Attn: Medical Review Clerk.

Name of Driver (<i>last, first, middle initial</i>)		Telephone Number				
Address (<i>number and street</i>)		City		State	ZIP Code	County
Date of Birth (<i>mm/dd/yyyy</i>)	Driver's License Number			Date of License Expiration (<i>mm/dd/yyyy</i>)		

I am requesting a driving ability review for the above named driver for the following reason:

(This area is intentionally left blank for the requester to provide details on the reason for the driving ability review.)

I swear or affirm that the information I have entered on this form is correct. I understand that making a false statement may constitute the crime of perjury.

Signature of Requester		Printed Name		Date (<i>mm/dd/yyyy</i>)	
Address (<i>number and street</i>)		City		State	ZIP Code
Affiliation					
<input type="checkbox"/> Law Enforcement: Badge Number _____ <input type="checkbox"/> Prosecutor <input type="checkbox"/> BMV/C Personnel <input type="checkbox"/> Medical/General Power of Attorney <input type="checkbox"/> Rehabilitation/Medical Center <input type="checkbox"/> Physician <input type="checkbox"/> Court Appointed Guardian/Custodian <input type="checkbox"/> Other: _____					