

BUREAU OF MOTOR VEHICLES CREDENTIAL PROGRAMS

100 North Senate Avenue, Room N402 Indianapolis, IN 46204

- 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 (last, first, middle initial)				Telephone Number ()		
Address (number and street)		City	State	ZIP Code	County	
Date of Birth (mm/dd/yyyy)	Driver's License Num	n ber	Date of License Expiration (mm/dd/yyyy)			
am requesting a driving ability review f	or the above named driv	ver for the following reason:				
I swear or affirm that the information of perjury.	I have entered on this	form is correct. I understand that	at making a fa	lse statement may	constitute the crin	
Signatureof Requester	-	Printed Name		Date (mm/dd/yyyy)		
Address (number and street)		City		State	ZIP Code	
Affiliation					1	
☐ Law Enforcement: Badge N		Prosecutor ☐ BMV/C Personne		al/General Power of A	Attorney	
□ Rehabilitation/Medical Cent	ter 🗌 Physician 🔲	Court Appointed Guardian/Custodi	ian 🗌 Other	:		