

REQUEST FOR DRIVER EVALUATION

INSTRUCTIONS:

- 1) Complete this form if you wish for the Department of Driver Services (DDS) to evaluate a driver's ability to drive safely.
- 2) Sign this request in the signature box provided. **Anonymous reports will not be considered.** You may request that your name not be revealed to the individual being reported. Confidentiality will be honored to the fullest extent possible.
- 3) Mail your completed request to : **Georgia Department of Driver Services**

**Customer Service, Licensing and Records Division
2206 East View Parkway
Conyers, GA 30013**

*The driver does not have to be cited. Please indicate evidence of the incapacity in the area below. If the driver was involved in a traffic accident, attach a copy of the report.

SECTION COMPLETION REQUIRED

Name of Person being reported (First, MI, Last)	Date of Birth or Approximate Age	Telephone Number
Driver License Number	Vehicle License Plate Number, if available	
Street Address	City	State Zip Code

DRIVER CONDITION: Check all appropriate boxes below. Please use the space below to provide specific dates, if known, about the driver's medical (physical or mental) condition such as name of disease or illness, any medications taken, etc.

<input type="checkbox"/> Medical Condition	<input type="checkbox"/> Confused/Disoriented
<input type="checkbox"/> Physical Condition	<input type="checkbox"/> Alcohol/Drug Use (Describe below)
<input type="checkbox"/> Mental/Emotional Condition	<input type="checkbox"/> Blackouts, Seizures, Fainting Spells
<input type="checkbox"/> Vision Condition	<input type="checkbox"/> Needs help with daily activities (i.e. cooking, dressing, bathing etc.)
<input type="checkbox"/> Weakness or Coordination Problems	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Difficulty Walking	

DRIVER BEHAVIOR: Check appropriate boxes for driving problems you have observed (Use space below for additional comments as needed).

<input type="checkbox"/> Does not see or react to other cars, pedestrians etc.	<input type="checkbox"/> Turns in front of on-coming cars
<input type="checkbox"/> Drives in wrong lane	<input type="checkbox"/> Allows car to drift in and out of lane
<input type="checkbox"/> Drives on wrong side of road	<input type="checkbox"/> Backs up or changes lanes without looking back or checking mirrors
<input type="checkbox"/> Acts violent or aggressive when driving	<input type="checkbox"/> Applies brake and gas pedals at the same time
<input type="checkbox"/> Drives too slow, or stops, for no reason	<input type="checkbox"/> Slow reactions that may be caused by medication or drugs
<input type="checkbox"/> Is confused by traffic	<input type="checkbox"/> Drives on sidewalk
<input type="checkbox"/> Has trouble steering, braking or otherwise controlling car	<input type="checkbox"/> Makes driving mistakes while talking to passengers
<input type="checkbox"/> Gets lost or confused while driving near home	<input type="checkbox"/> Falls asleep while driving
<input type="checkbox"/> Fails to react to traffic signals, other cars, or pedestrians	<input type="checkbox"/> Other actions (describe below)
<input type="checkbox"/> Makes turns from wrong lane	

You may use the space below to further describe the driver's condition(s) or action(s) which led you to believe this driver should be evaluated by DDS. Describe any impairment, serious physical injury or illness, mental impairment or disorientation. Describe any traffic law violations whether or not a citation was issued.

The following section must be completed, including a signature and date in order for DDS to initiate an evaluation.

Your relationship to driver (check one):
 Relative (Please state exact relationship): _____
 Law Enforcement Officer Physician Caregiver Vision Specialist Other: _____

Check here if you would like to have your name kept confidential. Confidentiality will be honored to the fullest extent possible.

Your Name (Please Print) _____ Daytime Telephone Number _____

Your Mailing Address (City, State, Zip Code) _____

I certify (or declare) under penalty of perjury under the laws of the State of Georgia that the information I have provided is true and correct.

SIGNATURE REQUIRED _____ **DATE REQUIRED** _____

