West Virginia Department of Transportation

Division of Motor Vehicles

MEDICAL REVIEW REQUEST

WV DMV Medical Review Services
PO Box 17030, Charleston, WV 25317
Phone: 1-800-642-9066 Fax: (304) 957-0323
www.dmv.wv.gov

Purpose: Use this form to request that the Division of Motor Vehicles (DMV) conduct a medical review or driver skills review of a licensee.

Instructions: To be completed by physicians, law enforcement personnel, DMV employees, immediate family members or caregivers.

Driver Information

NAME *Last*	*First*	*Middle*	**GENDER** ☐ Male ☐ Female

WV Driver's License Number	Birthdate (mm/dd/yyyy)	Telephone Number

Resident Street Address	City	State	Zip Code
Mailing Address *(if different from above)*	City	State	Zip Code

To be Completed by Medical Professional Only

☐ Based on my observation, I believe the driver named above should have driving privileges suspended immediately.

Describe in detail the circumstances that led to this request. *Please provide as much information as possible, including what appears to be the driver's mental, physical or visual impairment. Use an additional sheet of paper, if necessary.*

Requester's Name	Relationship to Driver	
Organization/Law Enforcement Agency Name	Telephone Number	Fax Number

Business Street Address	City	State	Zip Code
Requester's Signature		Date (mm/dd/yyyy)	