

Driver Safety Concern Form

INSTRUCTIONS

1. Complete this form when requesting the Ministry of Transportation (MT) evaluate a driver's ability to drive safely.
2. Sign this Form in the signature block provided. Anonymous requests will not be honored.
3. Mail, fax or take this form to:

NAME OF PERSON TO BE EVALUATED

_____/_____/_____
DATE OF BIRTH (if known) m/d/yr

STREET ADDRESS (if known)

CITY

PROVINCE

POSTAL CODE

The MT may require evaluation when there is reason to believe that a driver may no longer be qualified to hold a license or when there is reason to believe that the person requires assessment for adaptive aids or re-education. The individual may be required to undergo a medical assessment, vision tests, a test on knowledge about driving, or an on-road driving test. In the space below please provide specific information such as events and dates of these events that caused you to question the individual's ability to drive safely. If you believe that the individual has a medical condition/functional impairment that impacts on safe driving, please provide information about the condition/impairment and if known to you, its impact on the individual's ability to drive safely. The information provided on this report will help the MT identify the steps necessary to determine the driver's qualifications. (If additional space is needed, please use the back of this form).

REQUESTS BASED EXCLUSIVELY ON AGE WILL NOT BE PROCESSED

Check here if you want your name kept confidential. The MT may not be able to keep this request confidential if the driver requests a hearing or files a lawsuit against the MT.

YOUR RELATIONSHIP TO THE PERSON

Physician (specify): _____

Other Health Care Provider (specify): _____

YOUR NAME

YOUR SIGNATURE

_____/_____/_____
DATE m/d/year

ADDRESS

DAYTIME TELEPHONE NUMBER