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 block provided. Anonymous reports will not be considered unless you are an immediate family member. 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: 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.*

NAME OF PERSON BEING REPORTED *(FIRST, M.I., LAST)*	DATE OF BIRTH OR APPROXIMATE AGE	TELEPHONE NUMBER ( )
DRIVER LICENSE NUMBER	VEHICLE LICENSE PLATE NUMBER, IF AVALIABLE	
STREET ADDRESS	CITY	STATE ZIP CODE

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

- ☐ Medical Condition
- ☐ Physical Condition
- ☐ Mental/Emotional Condition
- ☐ Vision Condition
- ☐ Weakness or Coordination Probelms
- ☐ Difficulty Walking
- ☐ Confused/Disoriented
- ☐ Alcohol/Drug Use (Describe below)
- ☐ Blackouts, Seizures, Fainting Spells
- ☐ Needs help with daily activities (i.e. cooking, dressing, bathing, balancing checkbook)
- ☐ Other:____________________

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

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

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.

YOUR RELATIONSHIP TO DRIVER:

☐ 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.

NAME *(Please print)*	DAYTIME TELEPHONE NUMBER ( )
YOUR MAILING ADDRESS *(City, State, Zip Code)*	

Do you wish to be notified of the results? ☐ Yes ☐ No If Yes, please provide email:

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 X	DATE