

Driver Evaluation Request

You can use this form to request we evaluate an individual's driving ability. You must provide specific information about their medical/visual conditions and/or driving ability. Age is not a consideration. Based on the information provided, we will investigate and take action as necessary. Insufficient information may result in no action. We are unable to divulge the outcome to you, however, **we will provide this form to the driver or their attorney upon written request.**

Additional witnesses must complete separate forms.

Return this form and any additional information or documents to:
Driver Records, Department of Licensing, PO Box 9030, Olympia, WA 98507-9030

Based on my personal observation and knowledge, I request the Department evaluate this driver's qualifications.

Name of driver <i>(First, Middle, Last)</i>			Date of birth
Residence address			
City	State	ZIP code	Driver license number
<p>Statement</p> <p><i>I am concerned that this driver has one or more of the following conditions that may affect their ability to safely drive:</i></p> <p> <input type="checkbox"/> Medical condition <input type="checkbox"/> Vision condition <input type="checkbox"/> Poor driving skills </p>			
<p>Details</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
<p>Knowledge of this driver is based on observation as a</p> <p> <input type="checkbox"/> Law enforcement officer Agency _____ Badge number _____ <input type="checkbox"/> Check here if there was a collision with a serious injury or fatality and the driver was at fault </p> <p> <input type="checkbox"/> Medical professional Professional license number _____ </p> <p> <input type="checkbox"/> Concerned citizen </p>			
Name of requestor <i>(First, Middle, Last)</i>			
Mailing address			
City	State	ZIP code	(Area code) Telephone number

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

_____ **X**
 Date and place Signature