



DEPARTMENT OF FINANCE AND ADMINISTRATION
Office of Driver Services, Driver Control
Age Waiver-Medical Verification

Only for serious illnesses of age waiver applicant or immediate family members. Family members may include parents, grandparents, stepparents or legal guardians if living in the same household as applicant.

If the person with the medical condition holds a valid Arkansas driver's license, they could possibly be contacted by The Office of Driver Services to determine if an evaluation is needed to maintain their driving privileges.

AGE WAIVER APPLICANT NAME		DRIVER'S LICENSE NUMBER
IS THE MEDICAL REQUEST FOR YOU OR A FAMILY MEMBER? <input type="checkbox"/> MYSELF <input type="checkbox"/> FAMILY MEMBER		FAMILY MEMBER NAME
MEDICAL INFORMATION:		
NAME OF DOCTOR OR MEDICAL FACILITY		MEDICAL RECORD/PATIENT FILE NUMBER
ADDRESS OF DOCTOR OR MEDICAL FACILITY		DATE
TREATMENT UNDER YOUR SUPERVISION		
DIAGNOSIS?		
DO YOU NEED TO SEE YOUR PATIENT REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	FREQUENCY OF VISITS?	
PROGNOSIS?		
IS THE CONDITION <input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Worsening or deteriorating <input type="checkbox"/> Subject to change		
WOULD THE SIDE EFFECTS FROM THE PRESCRIBED MEDICATIONS INTERFERE WITH YOUR PATIENT'S ABILITY TO DRIVE SAFELY? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain:		
DOES YOUR PATIENT'S MEDICAL CONDITION AFFECT SAFE DRIVING? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain:		

ADDITIONAL INFORMATION: _____

I certify that all information is true and correct.

SIGNATURE OF DOCTOR OR NURSE	
PHONE NUMBER	DATE