www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

MISSING OR IMPAIRED LIMB ASSESSMENT FOR NON-COMMERCIAL DRIVERS

Purpose: Use this form to request medical information from your physician, physician assistant or nurse practitioner.

Instructions: Follow the detailed INSTRUCTIONS printed on page 2. Take the entire MED 8 and DMV letter to your physician, physician assistant or nurse practitioner to complete page 3. Note: Any charges related to or incurred as part of the completion of this form are the customer's responsibility.

CUSTOMER INFORMATION

NAME (Last) (First) (MI) (Suffix)			CUSTOMER NUMBER (from your driver's license) or SSN
RESIDENCE/HOME ADDRESS			☐ Check if this is a new address, your address will be changed on DMV's system.
CITY	STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE

MAILING ADDRESS (if different from above)			
CITY	STATE	ZIP CODE	DAYTIME TELEPHONE NUMBER

BIRTH DATE (mm/dd/yyyy)	SEX ☐ MALE ☐ FEMALE	WEIGHT lbs	HEIGHT FT IN	

Describe, in detail, your medical condition.

Do you take prescription/non-prescription medications? ☐ YES ☐ NO If Yes, list below. (attach a separate sheet if more space is required)

NON-PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN	PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN

Have you ever experienced a blackout, seizure, loss of consciousness, or syncope? ☐ YES ☐ NO If Yes, enter date of last episode.	DATE (mm/dd/yyyy)	Did the episode result in a motor vehicle crash? ☐ YES ☐ NO

Explain what happened during the episode.

COMMERCIAL DRIVER LICENSE DISABILITY WAIVER OR HAZARDOUS MATERIALS VARIANCE

Are you applying for a commercial driver license disability waiver or a hazardous materials variance? ☐ YES ☐ NO
If YES, a CDL Disability Waiver or Hazardous Materials Variance Application (MED 30) must also be submitted.

INFORMATION RELEASE APPROVAL

I authorize _____ and/or_____, a licensed medical provider to complete this Customer Medical Report, submit it to DMV and, if necessary to provide further clarification or information to DMV about my physical and/or mental condition. I consent to DMV using this information to arrive at a decision concerning my ability to safely operate a motor vehicle. I also authorize DMV to use the above customer information to correctly identify my records on file in accordance with the Virginia Privacy Protection Act of 1976. I understand that Virginia Code § 46.2-208(b)(1) prohibits DMV from releasing medical data to anyone other than a physician, physician assistant or nurse practitioner

CUSTOMER SIGNATURE AND AUTHORIZATION (parent must sign for a minor)	DATE (mm/dd/yyyy)

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MISSING OR IMPAIRED LIMB ASSESSMENT FOR NON-COMMERCIAL DRIVERS INSTRUCTIONS

Purpose: Use these instructions to complete the Missing or Impaired Limb Assessment for Non-Commercial Drivers form (MED 8).

CUSTOMER INSTRUCTIONS

1. Review all correspondence received from the Department of Motor Vehicles (DMV) regarding concerns about your ability to safely operate a motor vehicle.
   - If you received an Official Notice/Order of Suspension, you must provide DMV with the required Missing or Impaired Limb Assessment form (MED 8), prior to the effective date noted in the Notice/Order to avoid having your driving privilege suspended.
   - If your driving privilege is suspended, you will be required to provide proof of legal presence in order to reinstate your driver's license, if you have not already provided proof.
2. Complete the sections of the MED 8 titled “Customer Information” and “Information Release Approval”. Be sure to provide your signature at the end of the “Information Release Approval” section.
3. Take the entire MED 8 and your **DMV letter to your medical provider at the time of your medical examination.**
4. Request your medical provider to complete page 3 and return the report to DMV .

   Note: you will be notified of any decisions regarding your driving privilege based on:
   - Medical and other related information received from your medical provider,
   - DMV driver license test results and/or a certified independent driver rehabilitation evaluation (if required),
   - DMV medical review policies and guidelines as established in collaboration with the DMV Medical Advisory Board.
5. If you have questions related to DMV's requirement for you to submit a MED 8, you may contact DMV Medical Review Services:
   - Mail - send your request in writing to Medical Review Services at the address listed at the top of this form
   - Telephone - (Voice) 1-804-367-6203 or (Deaf/Hearing Impaired only) 1-800-272-9268
6. Providers may fax the completed Med 8 to DMV Medical Review Services at (804) 367-1604 or (804) 367-0520. Alternatively, the form may be mailed, in its original form, to the address at the top of this page.

MISSING OR IMPAIRED LIMB ASSESSMENT FOR NON-COMMERCIAL DRIVERS

(MUST BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER)

NAME (Last) (First) (MI) (Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN

PLEASE PROVIDE A DESCRIPTION OF THE MISSING OR IMPAIRED LIMB(S)

DATE OF IMPAIRMENT(S)	(mm/dd/yyyy)	(mm/dd/yyyy)	(mm/dd/yyyy)	(mm/dd/yyyy)	(mm/dd/yyyy)

CAUSE OF IMPAIRMENT(S)

DOES THE DRIVER HAVE ANY UNDERLYING MEDICAL CONDITION THAT CONTRIBUTED TO OR PRECIPATED THE IMPAIRMENT? ☐ YES ☐ NO

IF YES, IS THERE A RISK THE CONDITION MAY PROGRESS IN THE FUTURE? ☐ YES ☐ NO

HAS THE DRIVER BEEN EVALUATED BY DMV PREVIOUSLY? ☐ YES ☐ NO

GENERAL RECOMMENDATIONS

Is the patient's condition(s) stable? ☐ YES ☐ NO If No, explain.

Is the patient compliant with treatment? ☐ YES ☐ NO If No, explain:

Does the patient experience side effects of medications, which are likely to impair driving ability? ☐ YES ☐ NO If Yes, explain:

Based on this examination, is the patient medically capable of:
- safely operating a motor vehicle? ☐ YES ☐ NO
- safely operating a motorcycle? ☐ YES ☐ NO

Based on this examination, patient needs the following: (check each appropriate item)

☐ to be retested by DMV on ☐ Knowledge ☐ Road ☐ Both

☐ a driver evaluation (with a certified independent driver rehabilitation specialist CDRS).

For clarification on any of the above, contact Medical Review Services at 804 367-6203.

☐ an adaptive device/equipment required to safely operate a motor vehicle.
if adaptive device/equipment required, is it currently used? ☐ YES ☐ NO

☐ a prosthetic/orthotic device to operate a motor vehicle

Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)

☐ Sensor/motor Function ☐ Strength and Endurance ☐ Maneuvering Skills

☐ Reaction Time ☐ Range of Motion ☐ Use of Arm(s) and/or Leg(s)

ADDITIONAL RECOMMENDED RESTRICTIONS	OTHER COMMENTS/CONCERNS

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)	MEDICAL SPECIALTY

MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)	ISSUING STATE	TELEPHONE NUMBER ( )	FAX NUMBER ( )

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE	DATE (mm/dd/yyyy)

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.