Department of Public Safety

DRIVER COMPLIANCE DIVISION

REQUEST FOR DRIVER REVIEW

Please **print** or **type**

"✶" areas **must** be completed.

I request that the below named individual be re-examined for the privilege of

✶ Driver's Name *Last* *First* *Middle*			✶ Date of Birth
Telephone Number	Vehicle Plate Number	✶ DL/SS Number	
✶ Residence Address			County of Residence
✶ City	✶ State	Zip	
Mailing Address (if different from above address)			
City	State	Zip	

Based on my observation, I believe this individual should be reviewed for the following concerns:

☐ **Medical Examination** ☐ Vision Examination ☐ **Written Examination** ☐ **Driving Skills Examination** ☐ Other

I understand that DPS may have additional requirements.

✶ Please describe in detail, the circumstances that led to this request. (Include a description of what appears to be the driver's physical, mental or visual impairment - or other reason for review. Use back of form or attach pages if necessary.)

✶ Requestor's Name (Print or Type)	✶ Signature	✶ Date
Organization Name (if applicable)	Telephone Number	
✶ Address		
✶ City	✶ State	✶ Zip

MAIL COMPLETED REQUEST TO: Department of Public Safety
Medical Section
P.O. Box 11415
Oklahoma City, OK 73136-0415

TELEPHONE: (405) 425-2059

NOTICE: The Department of Public Safety cannot guarantee that the requestor on this form will remain anonymous throughout any review process which may be initiated as a result of this request.