Dear Applicant:

To assist the Department of Public Safety in evaluating your application for a drivers license, please have the attached questionnaire completed by one of the following most familiar with your medical history:

a) The facility where you received treatment;

b) Licensed psychiatrist, a psychologist licensed in Oklahoma, or a doctoral level psychologist licensed for independent practice in another state;

c) Licensed physician specializing in substance abuse treatment;

d) Alcohol/drug counselor certified by the state Department of Mental Health Substance Abuse Services.

After the questionnaire has been received and reviewed, you will be notified by mail of the results of the evaluation. Thank you for your cooperation.
Oklahoma Department of Public Safety
Substance Abuse Questionnaire

Name of Applicant: ____________________________ Date of Birth: __________
Mailing Address: ____________________________ City: _______________ Zip: ______

*** This form must be completed by: a licensed psychiatrist, a psychologist licensed in Oklahoma, or a doctoral level psychologist licensed for independent practice in another state, physician specialized in substance abuse treatment, or certified substance abuse counselor. ***

(If additional space is needed, attach supplemental sheet)

1) Medical History (to include type of drug abused, frequency of use and date of last use):

2) Diagnostic test results (attach copies of test results if available):

3) Treatment Recommendations (include any previous treatment received or if current treatment is being received):

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4) Recovery Prognosis:

5) In your professional opinion, does this person have the substance abuse problem under control?  
Yes ___ No ___. If no, please explain:

______________________________________________  
Date Report Completed

______________________________________________  
Signature

______________________________________________  
Print Name

______________________________________________  
Certificate Number and Specialty

______________________________________________  
Mailing Address

______________________________________________  
City  State  Zip

(_______)  
Phone Number

Mail completed form to:  
Exec Secy. Medical Advisory Committee  
Department of Public Safety  
P.O. Box 11415  
Oklahoma City, OK 73136-0415