



MISSOURI DEPARTMENT OF REVENUE
 DRIVER LICENSE BUREAU, P.O. BOX 200
 301 WEST HIGH STREET, ROOM 470
 JEFFERSON CITY, MO 65105-0200
DRIVER CONDITION REPORT

TELEPHONE: (573) 751-2730
 FAX: (573) 522-8174
 WEB SITE: www.dor.mo.gov

FORM
4319
 (REV 04-2010)

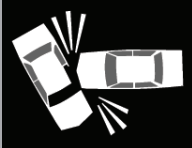
Please complete the Driver Condition Report if you have personal knowledge about a driver you believe is no longer able to safely operate a motor vehicle.

- ▶ You should report only your firsthand knowledge of the driver.
- ▶ You should complete the entire form and sign your name on the reverse side.
- ▶ After reviewing this report, the Director of Revenue may require the driver to take certain tests such as a medical, vision or driving test.
- ▶ All information contained in this report shall be kept confidential, unless released by a court order.

PERSONAL INFORMATION ON PERSON BEING REPORTED: Please complete all available information.	NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER OR DRIVER LICENSE NUMBER		
	LICENSE PLATE NUMBER	STATE OF ISSUANCE	DATE OF BIRTH ____/____/____	TELEPHONE NUMBER (____) _____ - _____	
	ADDRESS		CITY	STATE	ZIP CODE _____

Describe in detail incidents or conditions about this driver. Give specific information such as dates, places, accident reports and all other available information to support the need for re-examination. You should report only information of which you have personal knowledge or physical evidence. Do not report what you have been told or heard.

DRIVER BEHAVIOR



Please check appropriate boxes based on personal knowledge of incident if applicable. Please give a detailed description of incident. Age alone is not a sufficient reason for retesting.

- Traffic Violations Lack of Attention
- Dangerous Actions Caused Traffic Accident/Incident
- Poor Driving Skills

LOCATION _____	
DATE	TIME

- Lack of Knowledge of Traffic Laws
- Obstructing Traffic
- Other _____



MEDICAL CONDITIONS

Please check appropriate boxes if the driver being reported has any of the following conditions that would impair his or her ability to safely operate a motor vehicle:

COGNITIVE IMPAIRMENTS/PSYCHIATRIC DISORDER
(i.e., sees or hears things that are not there, gets lost easily, has problems remembering words for common things, confusion in thought process or judgment)

Please explain: _____

VISUAL IMPAIRMENT
(frequently runs into objects, cannot see road signs, cannot see objects on the side without turning head)

Please explain: _____

ALCOHOL/DRUG ABUSE

Please explain: _____

DISORDERS THAT IMPAIR CONSCIOUSNESS
(i.e., seizures, blackouts, sleep disorders)

When was the last loss of consciousness?

_____/_____/_____
(month) (day) (year)

Please explain: _____

LIMITED MOBILITY
(i.e., paralysis, problems moving freely)

Please explain: _____

OTHER CONDITIONS

Please explain: _____

ADDITIONAL COMMENTS

Please attach additional comments if necessary.

PERSON COMPLETING FORM:



Based on my observation(s) of the above named person and/or information relayed to me by the individual, I reasonably and in good faith, believe that he/she cannot safely operate a motor vehicle.

PRINT FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO DRIVER		TELEPHONE NUMBER () - - - -
STREET ADDRESS	CITY	STATE	ZIP CODE - - - - -
SIGNATURE			DATE / /

ANY PERSON WHO INTENTIONALLY FILES A FALSE REPORT SHALL BE GUILTY OF A CLASS A MISDEMEANOR, AND SHALL BE LIABLE FOR THE DAMAGES WHICH RESULT.