



Missouri Department of Revenue  
**Driver Condition Report**

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.
- A driver condition report must be completed by one of the following: a physician, chiropractor, registered nurse, psychologist, law enforcement personnel, social worker, professional counselor, optometrist, physical or occupational therapist, emergency medical technician, or immediate family of the driver. (Immediate family members consist of spouse, parent, child, grandparent, sibling, grandchild, great grandparent, aunt, uncle, niece, nephew, or great grandchild. In-laws are excluded as immediate family members).

**Driver's Personal Information**

Please provide all information available for the person being reported.

Name (Last, First, Middle)			Social Security or Driver License Number	
License Plate Number	State of Issuance	Date of Birth (MM/DD/YYYY) ____/____/____	Telephone Number (____)____-____	
Address		City	State	Zip Code

**Detail Incidents and Conditions**

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 select 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.

<input type="checkbox"/> Traffic Violation  <input type="checkbox"/> Lack of Attention  <input type="checkbox"/> Dangerous Actions  <input type="checkbox"/> Poor Driving Skills  <input type="checkbox"/> Caused Traffic Accident or Incident	Location	
	Date (MM/DD/YYYY) ____/____/____	Time
	<input type="checkbox"/> Lack of Knowledge of Traffic Laws  <input type="checkbox"/> Obstructing Traffic  <input type="checkbox"/> Other _____ _____ _____	

Medical Conditions

Please select 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. Physicians, please complete Form 1528 and attach to this report.

Cognitive Impairments or 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  
(i.e., frequently runs into objects, cannot see road signs, cannot see objects on the side without turning head). Please explain:  
\_\_\_\_\_

Alcohol or Drug Abuse  
Please explain:  
\_\_\_\_\_

Disorders That Impair Consciousness  
(i.e., seizures, blackouts, sleep disorders) When was the last loss of consciousness? \_\_\_ / \_\_\_ / \_\_\_  
Please explain: MM/DD/YYYY  
\_\_\_\_\_

Limited Mobility  
(i.e., paralysis, problems moving freely) Please explain:  
\_\_\_\_\_

Other Conditions or Additional Comments  
Please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reporter's Personal Information and Signature

Under penalties of perjury, I declare that the above information and any attached supplement is true, complete, and correct. Based on my observation(s) of the above named person and information relayed to me by the individual, I reasonably and in good faith, believe that he or she cannot safely operate a motor vehicle. I understand that 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.

Full Name (Last, First, Middle)		Relationship to Driver
Address		City
State	Zip Code	Telephone Number ( ___ ___ ___ ) ___ ___ - ___ ___
Signature		Date (MM/DD/YYYY) ___ / ___ / ___

**Mail to:** Driver License Bureau  
P.O. Box 200  
Jefferson City, MO 65105-0200

**Phone:** (573) 526-2407  
**Fax:** (573) 522-8174  
**E-mail:** [dlbmail@dor.mo.gov](mailto:dlbmail@dor.mo.gov)

Visit [www.dor.mo.gov/drivers/](http://www.dor.mo.gov/drivers/)  
for additional information.

Form 4319 (Revised 11-2017)

