



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 6-2008)

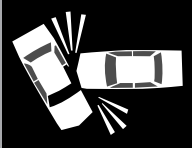
Please complete the Driver Condition Report if you have personal knowledge about a driver you believe is no longer able to safely operate a motor vehicle.

- ▶ 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.

<b>PERSONAL INFORMATION ON PERSON BEING REPORTED:</b>  <b>Please complete all available information.</b>	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.