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MISSOURI DEPARTMENT OF REVENUE

Form 5839 Physician's Statement and Authorization for Medical Alert Notation

A person wanting to add a medical alert notation must have this form completed by a licensed provider and present it at the time of application for the driver license or nondriver ID pursuant to **Section 302.205, RSMo**.

Application and issuance of a driver license or nondriver ID with a medical alert notation indicates your consent to the release of such medical information. This consent includes anyone who sees your license or those you allow to copy or scan your license. Such consent may also apply to persons otherwise ineligible to access such medical information under state or federal law.

This form must be completed in full and signed by a person licensed to practice medicine or psychology in Missouri within one year of application date as verification of eligibility to obtain a medical alert notation on a driver license or nondriver ID. A stamped signature is not acceptable. The issuance of a medical alert notation on a driver license or nondriver ID is not for the purpose of any determination of eligibility for any public benefit.

Patient Information

Last Name	First Name	Middle

Date of Birth (MM/DD/YYYY)	Driver License Number
___ ___/___ ___/___ ___ ___ ___	

Address	City	State	ZIP Code

Signature	Date (MM/DD/YYYY)
	___ ___/___ ___/___ ___ ___ ___

Medical Condition

- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Diabetes Mellitus (DM)
- ☐ Autism
- ☐ Drug Allergy (Drug Alrgy)
- ☐ Epilepsy (EPL)
- ☐ Alzheimers (ATD)
- ☐ Dementia (DEM)
- ☐ Schizophrenia (SCHZ)
- ☐ High Blood Pressure (HBP)
- ☐ Cardiovascular Disease (CVD)
- ☐ Speech Impairment (Speech Impaired)

Parent/Guardian Signature

I am the parent or legal guardian of a driver who is less than 18 years of age and is applying for a driver license or nondriver ID with a medical alert notation. In signing this statement I grant permission for the above listed individual to obtain a driver license or nondriver ID with the medical alert notation for the condition(s) noted above.

Signature	Printed Name	Date (MM/DD/YYYY)
		___ ___/___ ___/___ ___ ___ ___

Personal signature required of licensed provider, physician, physical therapist, occupational therapist licensed pursuant to **Chapter 334, RSMo.**, or other authorized licensed health care practitioner.

Physician Information

Printed Last Name	First Name	Middle	Telephone Number
			(___ ___ ___)___ ___ ___-___ ___ ___ ___

Address	City	State	ZIP Code

Physician Signature

Under penalties of perjury, I declare that the above information is true and accurate. I certify that I have examined the above named patient and have determined him or her to have the indicated condition, illness or disorder.

Signature	Printed Name

Registration Number	Date (MM/DD/YYYY)
	___ ___/___ ___/___ ___ ___ ___

Mail to: Driver License Bureau
PO Box 200
Jefferson City, MO 65105-0200

Phone: 573-751-2730

E-mail: dlbmail@dor.mo.gov

Visit **dor.mo.gov/driver-license/** for additional information.

Ever served on active duty in the United States Armed Forces?
If yes, visit **dor.mo.gov/military/** to see the services and benefits we offer to all eligible military individuals. A list of all state agency resources and benefits can be found at **veteranbenefits.mo.gov/state-benefits/**.