STATE OF FLORIDA
DEPARTMENT OF HIGHWAY SAFETY
AND MOTOR VEHICLES

Diabetes Form

RE: _____
DL#:_____
DOB: _____

Dear Physician:

This individual was reported to the Department after having an episode of hypoglycemia that resulted in a motor vehicle crash on <<enter date>>. We are in the process of assessing their ability to safely operate a motor vehicle and need your input on the following questions:

1. How long have you treated the patient? When did you last see the patient in your office?

2. Has the patient experienced any further episodes of hypoglycemia since the crash?
   Yes ____ No ____

   If the answer is yes, please provide the date(s) and severity of the reaction(s).

3. What is your assessment of how well the patient's diabetes is being managed?

4. What advice has the patient been given to prevent recurrence of hypoglycemia while driving?

5. To the best of your knowledge, is this patient sufficiently well instructed and conscientiously applying these instructions to the point that it is highly unlikely that they would have another episode of hypoglycemia while operating a motor vehicle? Yes _____ No _____

   Comments: _____

   _____

   _____

Mail this Completed Form to:
Bureau of Motorist Compliance
Medical Review Program
Neil Kirkman Building, MS 86
Tallahassee, Florida 32399-0500
Telephone No.: (850) 617-3814
Fax No.: (850) 617-3944

Signature of Physician: _____
Print Physician's Name: _____
Medical License #: _____
Address: _____
Telephone Number: _____
Date: _____