Reset Form

REQUEST FOR DRIVING ABILITY REVIEW

State Form 54750 (7-11)
BUREAU OF MOTOR VEHICLES

BUREAU OF MOTOR VEHICLES
CREDENTIAL PROGRAMS
100 North Senate Avenue, Room N402
Indianapolis, IN 46204

INSTRUCTIONS: *1. Complete in blue or black ink.*
2. Completed form must be submitted to the address above Attn: Medical Review Clerk.

Name of Driver (*last, first, middle initial)*		Telephone Number ( )		
Address *(number and street)*	City	State	ZIP Code	County
Date of Birth *(mm/dd/yyyy)*	Driver's License Number	Date of License Expiration *(mm/dd/yyyy)*		

I am requesting a driving ability review for the above named driver for the following reason:

I swear or affirm that the information I have entered on this form is correct. I understand that making a false statement may constitute the crime of perjury.

Signatureof Requester	Printed Name	Date *(mm/dd/yyyy)*	
Address *(number and street)*	City	State	ZIP Code

Affiliation

☐ Law Enforcement: Badge Number _____ ☐ Prosecutor ☐ BMV/C Personnel ☐ Medical/General Power of Attorney

☐ Rehabilitation/Medical Center ☐ Physician ☐ Court Appointed Guardian/Custodian ☐ Other:_____