STATE OF NORTH CAROLINA
DEPARTMENT OF TRANSPORTATION

ROY COOPER
GOVERNOR

J.R. "JOEY" HOPKINS
SECRETARY

Name: _____
Address: _____
City: _____

Customer No. _____

Dear Customer:

The Medical Adviser is requesting additional information to properly evaluate your case.

Enclosed is a Substance Abuse Evaluation Form. This form must be completed by a certified substance abuse counselor approved by the North Carolina Substance Abuse Professional Certification Board. A list of the counselors in your area is also enclosed. You must contact one of these counselors and arrange an appointment. To avoid cancellation of your driving privilege, the form must be completed and returned to the Division within 30 days from the date of this letter.

Please give this matter your immediate attention to expedite your medical evaluation. If you have questions, you may contact us at (919)861-3809 or fax number (919)733-9569.

If the Customer wishes to be considered for removal from the Medical Review Program, the Customer must submit a written request containing his/her name, date of birth and Driver License Number to Medical Review Program, 3112 Mail Service Center, Raleigh, NC 27697-3112.

Sincerely,

Director of Customer Compliance Services

Mailing Address
NC DIVISION OF MOTOR VEHICLES
MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER
RALEIGH NC 27699-3112

Telephone: (919) 861-3809
Fax: (919) 733-9569
Customer Service: 1-877-368-4968

Website: www.ncdot.gov

Location:
DMV HEADQUARTERS BUILDING
1417 N. CHURCH STREET
ROCKY MOUNT, NC 27804

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Re: Customer No.

1. Outline drug (prescription and non-prescription)/alcohol use including date of last use and pattern of use in past 12 months.

2. Give brief psychosocial history including family, work, legal history, abbreviated mental status, and treatment history.

3. If not currently using chemicals (alcohol/drugs), what is being done to support abstinence?

4. Does this individual meet the DSM-V criteria for alcohol/drug dependence (active or in remission) or alcohol/drug abuse? Circle appropriate selection (Remission indicates minimum of twelve months abstinence).

5. Evaluator's Recommendations: (recommend a set of goals and treatment plan (including further evaluations) for client's continued recovery.

6. List additional comments, if any.

7. Did you verbally review your findings with your client? Yes/No

Instructions:

Indicate the total number of pages submitted including this cover letter. List client's name and license number on each additional page.
Sign and date each page.

Evaluator's Signature: _____ Date: _____
Address: _____
Telephone Number: _____ Certification No. _____
Date of Evaluation: _____ Expiration Date: _____
Applicant's Telephone Number: (____) _____

Mail completed form as follows:

Division of Motor Vehicles
Medical Review Unit
3112 Mail Service Center
Raleigh, North Carolina 27699-3112

If you have questions, you may contact us at (919)861-3809 or fax number (919)733-9569.

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NORTH CAROLINA DIVISION OF MOTOR VEHICLES
DRIVER LICENSE SECTION
CONSENT/INFORMATION FORM

Dr. Ed. Rep. No. Dr. Ed. Sch. Bus
Driver please complete the following:

Date of Birth _____ Race ___ Sex ___ County _____

I hereby authorize Dr./Counselor_____to give any examination they deem necessary for the purpose of determining my physical fitness to operate a motor vehicle. I understand this authorization includes permission for this information to be reviewed by a medical advisor approved by the division for the purpose of a recommendation to be rendered to determine my driving needs and abilities.

SIGNATURE OF APPLICANT: _____
PARENT/GUARDIAN IF MINOR: _____
DATE _____

Telephone No.:Home (___)_____Business(___)_____
Are you ___Retired____ Disabled_____Occupation:_____
What type of vehicle do you drive? Automobile_____School Bus_____
Commercial Motor Vehicle_____Other_____
Does your job require driving? _____
_____

To Physician

When completing the Medical Report Form, please keep in mind the physical, mental and emotional requirements necessary for the safe operation of a motor vehicle, for the patient and public welfare. Please answer all questions and applicable parts of PP. 2-7, which list thereview of conditions pertinent to driving. If you circle "Yes" for any of these conditions, you should address all the questions pertaining on the proceeding pages. You do not need to answer questions on the form for which you circled "No". Upon completion of this form please make an overall statement about your patient's medical condition and its potential effect on safe driving.