Kansas Department of Revenue

LETTER OF CONCERN

Division of Vehicles
Medical/Vision Unit
Click this website link to open the Vehicles Page.

This form may be used to request an evaluation of a Kansas driver. You must complete all fields and choose which issues you believe may affect the driver's ability to safely operate a motor vehicle. The information you provide will be kept confidential. Upon receipt of this evaluation request, the driver in question will receive medical and vision forms, to have completed by their doctor(s) that are familiar with their condition(s), from exams which have occurred within the last ninety (90) days. If this office receives approval from the medical community, the driver will be required to take and pass a driving test at their local full service exam station for continuation of Kansas driving privileges.

Name of Driver (First, M.I., Last):	**Date of Birth (mm/dd/yyyy):**
Address:	**City, State, Zip:**
Driver's License Number:	**Vehicle Tag Number (if available):**

I am concerned that this driver has one or more of the following conditions that may affect their ability to safely operate a motor vehicle:

Check	**Specify Condition**	**Check**	**Specify Condition**
☐	Medical:	☐	Confused/Disoriented
☐	Physical:	☐	Neurological Diagnosis:
☐	Mental:	☐	Blackout/Seizure/Syncope Event
☐	Vision:	☐	Weakness/Coordination Problems
☐	Difficulty Walking	☐	Other:

Driver's behavior/issue(s) I observed. (Please check those that apply).

Check	**Specify Condition**	**Check**	**Specify Condition**
☐	Does not see/react to other cars, pedestrians etc.	☐	Turns in front of on-coming traffic
☐	Drives in wrong lane	☐	Dementia
☐	Drives on wrong side of the road	☐	Blackout/Seizure/Syncope Event
☐	Drives too slow, or stops, for no reason	☐	Exhibits confused behavior when stopped
☐	Is confused by traffic signs or signals	☐	Fails to react to traffic signals, other cars, etc.
☐	Turns from or into the wrong lane	☐	Applies brake and gas pedals at the same time
☐	Slow reactions that may be caused by medication	☐	Unaware of his/her surroundings or lost
☐	Difficulty steering, braking, or controlling the car	☐	Difficulty staying awake

You may use the field below to further describe the driver's condition(s) or action(s) which lead you to believe this driver should be evaluated by the Medical/Vision unit.

Knowledge of this driver is based on observation as a: (Please check and complete additional information)

☐ **Law Enforcement Officer**	**Agency:**	**Badge Number**

☐ Check here if there was an accident and the driver was at fault.

☐ **Medical / Vision Physician**	**Physician License Number:**

☐ **Concerned Citizen**	☐ **Family Member**	☐ **Other:**

_____ **Date**

_____ **Signature**

_____ **Print Name**

The request for an evaluation may be faxed or mailed to the **Medical / Vision Unit**:

Fax Number: **(785) 296-5857**
Mailing Address: **Division of Vehicles**
Medical / Vision Unit
PO Box 2188
Topeka, KS 66601-2188