MINNESOTA DEPARTMENT OF PUBLIC SAFETY
DRIVER AND VEHICLE SERVICES

Seizure / Loss of Consciousness

Print this completed form. This form can be mailed or submitted in person to Driver and Vehicle Services, 445 Minnesota Street - Ste. 170, St. Paul, Minnesota 55101-5170. It may also be faxed to 651-282-2463.

- This form is used to determine your eligibility for Minnesota driving privileges. Your verified statement on this form, plus a report from your doctor, is collected by the authority of Minnesota Statute 171.13 and will be used only by authorized Driver and Vehicle Services division personnel.
- Your doctor will need to express an opinion regarding your present physical condition as it pertains to your safe operation of a motor vehicle upon the streets and highways.
- *Loss of consciousness or voluntary control* means the inability to assume and retain upright posture without support, or the inability to respond rationally to external stimuli.
- Failure to provide and return the requested data **in 30 days** will result in the denial of your license request and cancelation of your driving privileges.
- If you need more information, please contact the DVS Driver Compliance unit at 651-296-2021 or 651-282-6555 (TTY).

Driver, Please Complete

Name (LAST, FIRST, MIDDLE) ______________________ Date of Birth (mm/dd/yy) __________

DL Number (OMIT DASHES)

Date of Last Episode of Lost Consciousness or Voluntary Control (mm/dd/yy) __________

I certify that since this episode(s), I have been episode-free.

Driver Signature ______________________ Date (mm/dd/yy) __________

To Be Completed By a Medical Physician — ***Medical Information Necessary to Determine Eligibility***

Number of Examinations Given (or) Length of Time Under My Care __________

Diagnosis __________ Diagnosis Date (mm/dd/yy) __________

Treatment (or) Medication __________ Results of Treatment __________

Is the patient cooperating with treatment? ◯ Yes ◯ No

Long-Term Prognosis __________

Short-Term Prognosis __________

Is the patient qualified, in all medical respects, to exercise reasonable and proper control over a motor and/or commercial vehicle? ◯ Yes ◯ No

Exceptions __________

A review examination should be required in *(choose one)*:

NOTE: A 6-month or 1-year review is required until episode-free for four years on medication. Leaving this question blank results in a 4-year review, if eligible. ◯ 6 months ◯ 1 year ◯ 2 years ◯ 3 years ◯ 4 years

Signature of Medical Physician ______________________ Date (mm/dd/yy) __________

Physician's Printed Name __________

Physician's Address __________