VERMONT

State of Vermont
DEPARTMENT OF MOTOR VEHICLES
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Agency of Transportation

To: Commissioner of Motor Vehicles

From:

Subject: Driver Evaluation Recommendation

It is hereby requested that you re-evaluate the following person:

Name: _____
Last First Middle

Address: _____
Street / PO Box

_____
City State Zip

Date of Birth: _____ **License / ID Number:** _____

Brief description of what brought this individual's operation difficulties to my attention:

Based on the above observations, I believe the person is experiencing a problem with:

- ☐ Vision – Eye Test Recommended
- ☐ Medical – Submission of Medical Report Recommended
- ☐ Psychiatric – Psychiatric Report Recommended
- ☐ Medication – Medical Report Recommended
- ☐ Coordination – Complete Re-Exam Recommended
- ☐ Reactions – Complete Re-Exam Recommended
- ☐ Other (Please explain):

_____ _____
Signature of Officer Date

_____ _____
Department Phone Number

_____
Officer's Email Address