

AFFIDAVIT FOR RE-CERTIFICATION

TO BE USED IN REPORTING POSSIBLE PHYSICAL/MENTAL IMPAIRMENT FOR REVIEW BY THE MEDICAL REVIEW BOARD. IF USED BY PHYSICIAN, STATE POLICE, JUDGE, OR OTHER COUNTY OFFICIAL ONLY ONE SIGNATURE IS REQUIRED. IF USED BY CITIZEN, TWO SIGNATURES ARE REQUIRED BEFORE WE CAN INITIATE A CASE.

FULL NAME: _____
(First) (Middle) (Last)

DRIVER'S LICENSE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

ADDRESS: _____
(Street or Box) (City) (State) (Zip)

Please include all details of observation, use of any special equipment, description of driving behavior, reason or reasons you feel the individual is not medically capable of operating a motor vehicle.

(If additional space is required, use reverse side)

After all information is complete, please return this form to the Kentucky Medical Review Board, Division of Driver Licensing, State Office Building, Frankfort, Kentucky 40622.

NAME (signature) ADDRESS CITY STATE ZIP

NAME (signature) ADDRESS CITY STATE ZIP

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, 19__.

SIGNATURE _____

OFFICIAL TITLE _____

MY COMMISSION EXPIRES _____

If the individual request a copy of this document we are required by law to disclose it.