www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

TRAUMATIC BRAIN INJURY DESIGNATION APPLICATION

Purpose: Use this form to apply for a traumatic brain injury **designation** on your driver's license.

Instructions: Have this form completed by a physician, nurse practitioner, or physician's assistant. Submit the completed form to a DMV customer service center along with the DL 1P.

APPLICANT INFORMATION (person with disability)

FULL LEGAL NAME (last) (first) (middle) (suffix)	DMV NUMBER OR SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yyyy)

NOTE: If you enter a residence or mailing address that is other than what is currently on DMV's system, complete an "Address Change Request" (ISD 01).

CURRENT RESIDENCE ADDRESS **(SEE NOTE ABOVE)**	CITY	STATE	ZIP CODE

CITY OR COUNTY OF RESIDENCE	DAYTIME TELEPHONE NUMBER OR CELL PHONE NUMBER ( )

MAILING ADDRESS (if different from above) **(SEE NOTE ABOVE)**	CITY	STATE	ZIP CODE

INJURY INFORMATION

DATE OF INJURY (mm/dd/yyyy)	TYPE OF INJURY

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTIONER MEDICAL ASSESSMENT

This patient has the following impairments:

☐ Visual Field Cut ☐ Residual Weakness: ☐ Right ☐ Left ☐ Seizure Treatment Required

☐ Slurred Speech ☐ Altered Gait

Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)

Judgment and Insight

☐ Problem Solving and Decision Making ☐ Cognitive Function

☐ Emotional or Behavioral Stability ☐ Reaction Time

Sensorimotor Function

☐ Strength and Endurance ☐ Maneuvering Skills

☐ Range of Motion ☐ Use of Arm(s) and/or Leg(s)

Is the patient's condition(s) stable? ☐ YES ☐ NO If No, explain.	Is the patient compliant with treatment? ☐ YES ☐ NO If No, explain:

Does the patient experience side effects of medications, which are likely to impair driving ability? ☐ YES ☐ NO If Yes, explain:

Based on this examination, is the patient medically capable of:

- safely operating a motor vehicle? ☐ YES ☐ NO
- safely operating a motorcycle? ☐ YES ☐ NO

Based on this examination, patient needs the following: (check each appropriate item)

☐ to be retested by DMV on ☐ Knowledge ☐ Road ☐ Both

☐ a driver evaluation (with a certified independent driver rehabilitation specialist CDRS).

☐ an adaptive device/equipment required to safely operate a motor vehicle.

☐ a prosthetic/orthotic device to operate a motor vehicle

For clarification on any of the above, contact Medical Review Services at 804 367-6203.

ADDITIONAL RECOMMENDED RESTRICTIONS	MEDICATIONS

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)	MEDICAL SPECIALTY

MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)	ISSUING STATE	TELEPHONE NUMBER ( )	FAX NUMBER ( )

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE	DATE (mm/dd/yyyy)

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.