

# Family Request For Re-Evaluation Of Driving Privileges

## Idaho Transportation Department



This form must be completed in full and signed by the person making the request.  
 Any questions can be answered by calling the medical desk at (208) 334-8736.  
 This request is subject to public record disclosure.

### Please Print or Type

Name of Person to be Evaluated	Driver's License Number or SSN	Date of Birth	
Address	City	State	Zip

### Type of Examination Requested

Complete evaluation (medical, visual, road test, written test)

Limited evaluation (check exams needed)

Medical Exam

Visual Exam

Road Test

Written Test

### Reason For Request

This recommendation is based upon personal observation and knowledge of the above individual. Explain type of impairment that affects the person's ability to safely operate a motor vehicle. Use additional sheets if necessary.

### Requestor's Relation to Driver (Immediate or step relatives)

Parent

Child

Sibling

Spouse

Legal Caregiver

Include POA documentation

Requestor's Name	Phone Number
Requestor's Signature	Date

I declare under penalty of perjury that the foregoing is true and correct.

**Mail request to:** Idaho Transportation Department  
 Driver Services Section - Medical Records  
 PO Box 7129  
 Boise ID 83707-1129

Email: [ITDMedDesk@itd.idaho.gov](mailto:ITDMedDesk@itd.idaho.gov)  
 Fax: (208) 332-4122