Family Request For Re-Evaluation Of Driving Privileges
Idaho Transportation Department

ITD 5539 (Rev. 1/24)
dmv.idaho.gov

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) 334-8000. 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