The Office of Driver Services, having good cause to believe that a licensed driver is incompetent or otherwise not qualified to be licensed may require the licensee to submit to an initial evaluation by a Driver Control Hearing Officer.

Law Enforcement, Medical Professionals, Motor Vehicle Administrations and concerned relative may report drivers who they think are no longer able to safely operate a motor vehicle.

**Completed forms can be submitted in the following ways:**

**By Mail:**
Driver Control
P.O. Box 1272  Room 1070
Little Rock, AR 72203

**By Fax:**
(501) 683-0955

**Email:**
arhearingofficers@dfa.arkansas.gov

**Important Information about Initial Evaluations:**

- Please be as specific as possible about the medical, vision and mental conditions of the driver and include all supporting documents possible.
- All information submitted must be of personal knowledge or observation.
- **The age of the driver will not be taken into consideration.** Referrals must only be made in the interest of public safety and not due to age alone.
- Based on the information provided, the driver may be required to have a medical evaluation and/or retake all or part of the driver’s license exam.
- The final determination will not be released to the person submitting the referral form.
- Immediate family members that request an evaluation will be required to attend the initial evaluation.
- Anonymous requests will not be accepted.

**SECTION 1– DRIVER’S PERSONAL INFORMATION**

<table>
<thead>
<tr>
<th>NAME (FIRST AND LAST)</th>
<th>DRIVER’S LICENSE NUMBER</th>
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<table>
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<tr>
<th>DATE OF BIRTH</th>
<th>TELEPHONE NUMBER</th>
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<thead>
<tr>
<th>ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
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**SECTION 2– DRIVER BEHAVIOR**

- Traffic Violations
- Lack of Attention
- Dangerous Actions
- Poor Driving Skills
- Accidents
- Lack of Knowledge of Traffic Laws

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<thead>
<tr>
<th>LOCATION</th>
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OTHER

____________________________________________________________________
____________________________________________________________________
ADDITIONAL INFORMATION REGARDING THE DRIVER’S BEHAVIOR

SECTION 3 – DRIVER’S MEDICAL CONDITIONS THAT COULD AFFECT DRIVING

SELECT ALL THAT APPLY

☐ Seizure, Convulsions or Epilepsy  ☐ Mental Illness
☐ Head, Neck, Spinal Injury or Disorder  ☐ Permanent Impairment
☐ Vision Disorder  ☐ Parkinson’s Disease
☐ Heart Attack, Stroke or Paralysis  ☐ Neurological Disorder
☐ Lung Disease  ☐ Spastic or Paralyzed Muscles
☐ Diabetes or High Blood Sugar  ☐ Dementia
☐ Drug or Alcohol Abuse  ☐ Taking Medications

PLEASE PROVIDE ADDITIONAL INFORMATION REGARDING MEDICAL CONDITIONS THAT COULD AFFECT THE LICENSEE’S ABILITY TO DRIVE

SECTION 4 – REQUESTOR’S INFORMATION

Under penalties of perjury, I declare that the above information and any attached supplement is true, complete and correct. Based solely on my observation(s) of the above-named driver and information relayed to me by the individual, I reasonably and in good faith, believe that they cannot safely operate a motor vehicle. I understand that I will be informed of by mail of the date, time and location of the initial evaluation and I am required to attend.  

SIGNATURE OF REQUESTOR

NAME (FIRST AND LAST)  DRIVER’S LICENSE NUMBER

DATE OF BIRTH  TELEPHONE NUMBER

ADDRESS  CITY  STATE  ZIP CODE