Minnesota Department of Public Safety
Driver and Vehicle Servies
Driver Evaluation Unit
445 Minnesota St., St. Paul, MN 55101-5170
drive.mn.gov

Loss of consciousness or voluntary control

This form is used to determine your eligibility for Minnesota driving privileges due to loss of consciousness or voluntary control. If you hold a commercial driver's license, additional waivers are required.

Loss of consciousness or voluntary control means you cannot stay upright without support or respond rationally to your surroundings. If you have questions, email pic.dvs@cx.mn.gov or call 651-201-7777 or 651-282-6555 (TTY).

Submit the completed form by mail to the address at the top of this form or fax at 651-282-2463.

Driver completes this section

Minnesota driver's license number _____Date of birth _____

First, middle and last name _____

Date of last episode of lost consciousness or voluntary control _____

I certify that since this episode, I have been episode-free.

Tennessen warning: Driver and Vehicle Services (DVS) collects the information on this form to determine your eligibility for driving privileges and to administer and enforce driver licensing laws under Minnesota Statutes chapter 171. The information requested on this form includes medical information necessary to evaluate whether you meet the medical qualifications for a driver's license.

You are not legally required to provide this information. However, if you do not provide the requested information, DVS may be unable to determine your medical eligibility for driving privileges and may deny, cancel, revoke, restrict, or otherwise take action on your driver's license.

The information you provide may be shared with individuals and entities authorized by state or federal law, including courts, law enforcement agencies, other licensing agencies, and government entities involved in the administration or enforcement of driver licensing and motor vehicle laws.

Medical information will be used only for purposes authorized by law. The information collected on this form is private data on individuals except as otherwise provided by state law.

By signing this form, you certify that the information provided is true and correct.

Driver signature_____ Date _____

Physician completes this section

All questions in this section must be answered for the application to be accepted.

Note to physician: Your report is advisory and will help DVS determine your patient's eligibility to drive. In accordance with Minnesota law, you are immune from liability due to reporting any physical or mental condition that significantly impairs a person's ability to safely operate a motor vehicle.

1. Patient's name _____
2. Number of examinations given or length of time under my care _____
3. Diagnosis _____ Date of first episode _____
4. Is the patient cooperating with treating the condition?

   ☐ Yes ☐ No

   a. Long-term prognosis _____

   b. Short-term prognosis _____
5. Is the patient medically qualified to exercise reasonable control over a motor vehicle?

   ☐ Yes ☐ No
6. Was the loss of consciousness or voluntary control caused by a single nonepileptic seizure?

   ☐ Yes ☐ No
7. Is the patient currently taking any prescribed antiseizure medication to control this medical condition?

   ☐ Yes ☐ No ☐ Not applicable

   a. If 'No', the date of discontinuation of prescribed antiseizure medication: _____
8. The patient should be required to submit this form every (select one):

   ☐ 6 months ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years

   ☐ No further review is required.

   Note: A six- or 12-month review is required until episode-free or four years on medication.

Signature of physician _____ Date _____

Printed name _____ Phone _____

Address _____

City _____ State _____ ZIP code _____