
# Driving Safety for All Ages

Lotherone Grier

Medical Review Unit

Georgia Department of Driver Services

# Medical Review Process

- Any driver may be evaluated for a physical or mental disability or disease that can disqualify him/her from driving.
- The Medical Review process is initiated when DDS receives written correspondence or the Request for Driver Review (DDS 270), from a relative, court, law enforcement officer, judge, doctor, or concerned citizen (non-anonymous).
- The DDS Medical Review Unit investigates all cases submitted for review and releases the appropriate determination concerning the driver's ability to safely operate a motor vehicle.
- Commercial driver's physical qualifications are regulated under the Federal Motor Carrier Safety Regulations (FMCSR) Subpart E, 391.41.

# REQUEST FOR DRIVER REVIEW DDS-270



## REQUEST FOR DRIVER REVIEW

**INSTRUCTIONS:**

1) Complete this form if you wish for the Department of Driver Services (DDS) to review a driver's ability to drive safely.
2) Sign and date this request. **Anonymous reports will not be considered.** You may request that your name not be revealed to the individual being reported. Confidentiality will be honored to the fullest extent possible.
3) Mail or fax your completed request to: **Georgia Department of Driver Services**
   **c/o Medical Review Unit**
   **P.O. Box 80447**
   **Conyers, GA 30013**
   **Fax to (770) 344-3629**

*The driver does not have to be cited. Please indicate evidence of the incapacity in the area below. If the driver was involved in a traffic accident, attach a copy of the report.

**SECTION COMPLETION REQUIRED**

Name of Person being reported (First, MI, Last) | Date of Birth or Approximate Age | Telephone Number

Driver License Number | Vehicle License Plate Number, if available

Street Address | City | State | Zip Code

**DRIVER CONDITION: Check all appropriate boxes below. Please use the space below to provide specific dates, if known, about the driver's medical (physical or mental) condition such as name of disease or illness, any medications taken, etc.**

| | | | |
|---|---|---|---|
| | Medical Condition | | Confused/Disoriented |
| | Physical Condition | | Alcohol/Drug Use (Describe below) |
| | Mental/Emotional Condition | | Blackouts/ Fainting Spells |
| | Vision Condition | | Seizures |
| | Weakness or Coordination Problems | | Needs help with daily activities (i.e. cooking, dressing, bathing etc.) |
| | Difficulty Walking | | Other: |

**DRIVER BEHAVIOR: Check appropriate boxes for driving problems you have observed (Use space below for additional comments as needed).**

| | | | |
|---|---|---|---|
| | Does not see or react to other cars, pedestrians etc. | | Turns in front of on-coming cars |
| | Drives in wrong lane | | Allows car to drift in and out of lane |
| | Drives on wrong side of road | | Backs up or changes lanes without looking back or checking mirrors |
| | Acts violent or aggressive when driving | | Applies brake and gas pedals at the same time |
| | Drives too slow, or stops, for no reason | | Slow reactions that may be caused by medication or drugs |
| | Is confused by traffic | | Drives on sidewalk |
| | Has trouble steering, braking or otherwise controlling car | | Makes driving mistakes while talking to passengers |
| | Gets lost or confused while driving near home | | Falls asleep while driving |
| | Fails to react to traffic signals, other cars, or pedestrians | | Other actions (describe below) |
| | Makes turns from wrong lane | | |

**You may use the space below to further describe the driver's condition(s) or action(s) which led you to believe this driver should be evaluated by DDS. Describe any impairment, serious physical injury or illness, mental impairment or disorientation. Describe any traffic law violations whether or not a citation was issued.**

**The following section must be completed, including a signature and date in order for DDS to initiate a review.**

Your relationship to driver (check one):

____ Relative (Please state exact relationship): _____

____ Law Enforcement Officer ____ Physician ____ Caregiver ____ Vision Specialist ____ Other: _____

____ Check here if you would like to have your name kept confidential. Confidentiality will be honored to the fullest extent possible.

Your Name (Please Print) | Daytime Telephone Number

Your Mailing Address (City, State, Zip Code)

I certify (or declare) under penalty of perjury under the laws of the State of Georgia that the information I have provided is true and correct.

**SIGNATURE REQUIRED** | **DATE REQUIRED**

DDS-270 (07/16)

# MEDICAL REPORT DDS-MR 287 Page 1 of 4



DDS Georgia Department Of Driver Services

## GEORGIA DEPARTMENT OF DRIVER SERVICES
## MEDICAL REPORT

### PATIENT INSTRUCTIONS

**IMPORTANT:**

1. Complete, date, and sign **page 1** of this report.
2. Give **pages 1-4** of this report and a copy of the DDS letter that lists the medical concern(s) to your licensed physician.
3. The physician must complete **pages 2-4**; sign and date **page 4**.
4. All drivers who wish to maintain a **Commercial Driver's License** MUST have this form completed by a medical provider on the approved Federal Motor Carrier Safety Administration (FMCSA)National Registry of Certified Medical Examiners. (https://www.fmcsa.dot.gov).
5. **All pages** of this report and a copy of the DDS letter MUST be mailed or faxed (with coversheet) by the medical provider directly to:

**Department of Driver Services**
**Medical Review Unit**
**PO Box 80447**
**Conyers, Georgia 30013 or**
**Fax to (770) 344-3629**

### PATIENT INFORMATION

Name: Last _____ First _____ MI _____ DOB (mm/dd/yyyy) _____

Physical Street Address _____

City _____ State _____ Zip Code _____ Driver's License # _____

**Please check the box next to the class of license you hold:**

Non-Commercial Class: C/CP ☐ M/MP ☐ D ☐

Commercial Class: A/AP ☐ B/BP ☐ C ☐

### PATIENT HISTORY

Please check "Yes" or "No" to indicate any conditions you have that could affect the safe operation of a motor vehicle.

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Physical impairments | ☐ | ☐ | Seizures, fits, blackouts, convulsions, or fainting spells |
| ☐ | ☐ | Orthopedic, musculoskeletal, bone, joint or muscle problems or diseases | ☐ | ☐ | Nervous, mental health or psychiatric problems or diseases |
| ☐ | ☐ | Neurological problems or diseases | ☐ | ☐ | Visual problems or diseases |
| ☐ | ☐ | Head or spinal injuries | ☐ | ☐ | Hearing problems |
| ☐ | ☐ | Cardiovascular problems or diseases | ☐ | ☐ | Diabetes |

Explain any "Yes" answer(s):

_____

_____

### PATIENT ATTESTATION

I hereby swear or affirm that the above answers are true to the best of my knowledge. I authorize _____, a licensed physician, to complete this examination and to provide further clarification or information about my medical condition to the Georgia Department of Driver Services (DDS). I agree that this Medical Report may be submitted to the DDS Driver's License Advisory Board, which consists of doctors licensed to practice throughout the State of Georgia, and that it may also be used for the guidance of the courts when necessary.

_____ _____

**Driver/Licensee Signature** **Date**

# MEDICAL REPORT DDS-MR 287 Page 2 of 4



Patient Name: Last: First: M.I.:

## SECTION B

### CARDIOVASCULAR, RESPIRATORY OR HYPERTENSIVE DISEASE

**Functional Capacity (American Heart Association (AHA)):**

- Class 1: No limitation physical activity
- Class 2: Slight limitation physical activity
- Class 3: Marked limitation physical activity
- Class 4: Complete limitation physical activity

**B. 1.** Functional capacity classification (Check one): ☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4

**B. 2.** Blood pressure: _____

**B. 3.** Edema: ☐ Yes ☐ No

**B. 4.** Dyspnea or angina? ☐ Yes ☐ No At rest? ☐ Yes ☐ No Slight exertion? ☐ Yes ☐ No Moderate? ☐ Yes ☐ No

**B. 5.** Any syncope? ☐ Yes ☐ No If 'yes', please indicate frequency and severity:

_____

_____

**B. 6.** Any syncopal episodes in the past 12 months? ☐ Yes ☐ No If 'yes', please explain:

_____

_____

**B. 7.** Does the patient have an implanted cardioverter defibrillator? ☐ Yes ☐ No

**B. 8.** Was last syncopal episode related to cardiovascular abnormalities or arrhythmias? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

**B. 9.** Any other findings or cardiovascular, respiratory, or hypertensive problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

## SECTION C

### NERVOUS, MENTAL HEALTH, PSYCHIATRIC, PSYCHOLOGICAL

**C. 1.** Any nervous, mental health, psychiatric or psychological problem that could impair driving ability? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

**C. 2.** Is patient currently under treatment and/or a psychiatrist's care? ☐ Yes ☐ No

**C. 3.** Is patient compliant with the prescribed treatment and/or medication(s)? ☐ Yes ☐ No

**C. 4.** Has substance abuse caused psychiatric symptoms? ☐ Yes ☐ No

**C. 5.** Any other findings or nervous, mental health, psychiatric or psychological problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

☐ If this box is checked, a psychiatric evaluation must be performed by a psychiatrist or psychologist and attached to this report with recommendations.

# MEDICAL REPORT DDS-MR 287 Page 3 of 4



Patient Name: Last: First: M.I.:

## SECTION B

### CARDIOVASCULAR, RESPIRATORY OR HYPERTENSIVE DISEASE

**Functional Capacity (American Heart Association (AHA)):**

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**B. 3.** Edema: ☐ Yes ☐ No

**B. 4.** Dyspnea or angina? ☐ Yes ☐ No At rest? ☐ Yes ☐ No Slight exertion? ☐ Yes ☐ No Moderate? ☐ Yes ☐ No

**B. 5.** Any syncope? ☐ Yes ☐ No If 'yes', please indicate frequency and severity:

_____

_____

**B. 6.** Any syncopal episodes in the past 12 months? ☐ Yes ☐ No If 'yes', please explain:

_____

_____

**B. 7.** Does the patient have an implanted cardioverter defibrillator? ☐ Yes ☐ No

**B. 8.** Was last syncopal episode related to cardiovascular abnormalities or arrhythmias? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

**B. 9.** Any other findings or cardiovascular, respiratory, or hypertensive problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

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**C. 1.** Any nervous, mental health, psychiatric or psychological problem that could impair driving ability? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

**C. 2.** Is patient currently under treatment and/or a psychiatrist's care? ☐ Yes ☐ No

**C. 3.** Is patient compliant with the prescribed treatment and/or medication(s)? ☐ Yes ☐ No

**C. 4.** Has substance abuse caused psychiatric symptoms? ☐ Yes ☐ No

**C. 5.** Any other findings or nervous, mental health, psychiatric or psychological problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

☐ If this box is checked, a psychiatric evaluation must be performed by a psychiatrist or psychologist and attached to this report with recommendations.

# MEDICAL REPORT DDS-MR 287 Page 4 of 4



Patient Name: Last: First: M.I.:

## SECTION B

### CARDIOVASCULAR, RESPIRATORY OR HYPERTENSIVE DISEASE

**Functional Capacity (American Heart Association (AHA)):**

- Class 1: No limitation physical activity
- Class 2: Slight limitation physical activity
- Class 3: Marked limitation physical activity
- Class 4: Complete limitation physical activity

**B. 1.** Functional capacity classification (Check one): ☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4

**B. 2.** Blood pressure: _____

**B. 3.** Edema: ☐ Yes ☐ No

**B. 4.** Dyspnea or angina? ☐ Yes ☐ No At rest? ☐ Yes ☐ No Slight exertion? ☐ Yes ☐ No Moderate? ☐ Yes ☐ No

**B. 5.** Any syncope? ☐ Yes ☐ No If 'yes', please indicate frequency and severity:

_____

_____

**B. 6.** Any syncopal episodes in the past 12 months? ☐ Yes ☐ No If 'yes', please explain:

_____

_____

**B. 7.** Does the patient have an implanted cardioverter defibrillator? ☐ Yes ☐ No

**B. 8.** Was last syncopal episode related to cardiovascular abnormalities or arrhythmias? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

**B. 9.** Any other findings or cardiovascular, respiratory, or hypertensive problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

## SECTION C

### NERVOUS, MENTAL HEALTH, PSYCHIATRIC, PSYCHOLOGICAL

**C. 1.** Any nervous, mental health, psychiatric or psychological problem that could impair driving ability? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

**C. 2.** Is patient currently under treatment and/or a psychiatrist's care? ☐ Yes ☐ No

**C. 3.** Is patient compliant with the prescribed treatment and/or medication(s)? ☐ Yes ☐ No

**C. 4.** Has substance abuse caused psychiatric symptoms? ☐ Yes ☐ No

**C. 5.** Any other findings or nervous, mental health, psychiatric or psychological problems which could affect patient's ability to safely operate a motor vehicle? ☐ Yes ☐ No
If 'yes', please explain: _____

_____

☐ If this box is checked, a psychiatric evaluation must be performed by a psychiatrist or psychologist and attached to this report with recommendations.

# VISION REPORT DDS-MR 274 Page 1 of 2



DDS Georgia Department Of Driver Services

## GEORGIA DEPARTMENT OF DRIVER SERVICES
## VISION REPORT

### INSTRUCTIONS

**IMPORTANT:**

1. This report MUST be completed by a licensed optometrist or ophthalmologist. (**This report should not be completed for Commercial Motor Vehicle Drivers.)**
2. If using form for **Online Renewal**, **Do Not Fax**. Form must be uploaded using a DDS account via our website at **dds.drives.ga.gov.**
3. If cleared to drive with **Bioptic** lenses, this report should be mailed or faxed (with coversheet) by a licensed optometrist or ophthalmologist to:

**Department of Driver Services**
**Medical Review Unit**
**P. O. Box 80447**
**Conyers, Georgia 30013**

**Fax: (770) 344-3629**

4. Documents submitted to the Georgia Department of Driver Services cannot be returned. They will be safely and securely destroyed.

### PATIENT INFORMATION

Name: Last _____ First _____ MI _____ DOB (mm/dd/yyyy) _____

Physical Street Address _____

City _____ State _____ Zip Code _____ Driver's License # _____

Phone Number _____ Email _____

### PATIENT ATTESTATION

I authorize _____, a licensed optometrist or ophthalmologist, to complete this examination and to provide further clarification or information about my visual acuity to the Georgia Department of Driver Services (DDS). I agree that this Vision Report may be submitted to the DDS Driver's License Advisory Board, which consists of doctors licensed to practice throughout the State of Georgia, and that it may also be used for the guidance of the courts when necessary.

_____ _____

**Driver/Licensee Signature** **Date**

### REPORT ON VISUAL EXAMINATION

**Pursuant to Georgia Law (O.C.G.A. §40-5-27) a driver must meet the following vision requirements to be issued a license:**

- Visual acuity of 20/60 or better, corrected, or uncorrected in at least one eye
- Horizontal field of vision with both eyes open of at least 140 degrees
- If only one eye has usable vision, the horizontal field of vision must be at least 70 degrees temporally and 50 degrees nasally.

If possible, measure the below at 20 feet. If not, state the distance used: _____

**BEST CORRECTED VISUAL ACUITY (BCVA)**
Please state the visual acuity in degrees.

| | RIGHT EYE | LEFT EYE | BOTH EYES |
|---|---|---|---|
| **Without corrective lenses** | 20/ _____ | 20/ _____ | 20/ _____ |
| **With corrective lenses** | 20/ _____ | 20/ _____ | 20/ _____ |
| **With bioptic telescope** | 20/ _____ | 20/ _____ | 20/ _____ |

# VISION REPORT DDS-MR 274 Page 2 of 2



Patient Name: Last: _____ First: _____ M.I.: _____

**HORIZONTAL PERCEPTION (Must be tested)**

Please state the horizontal field of vision in degrees.

**Right:** _____ degrees **Left:** _____ degrees **Total:** _____ degrees

**MONOCULAR VISION**

Does this person have monocular vision? ☐ Yes ☐ No If yes, please state the nasal and temporal fields in degrees.

**NASAL FIELD** _____ degrees **TEMPORAL FIELD** _____ degrees

☐ Check here if correction is achieved with other than conventional lenses. If box is checked, a detailed report must be attached.

**VISION REPORT PHYSICIAN'S STATEMENT**

**Date of Examination (mm/dd/yyyy):** _____

1. Is there double-vision? ☐ Yes ☐ No If 'Yes', is it corrected with glasses or other treatment? ☐ Yes ☐ No
2. Is there any evidence of eye disease, condition, or injury? ☐ Yes ☐ No If 'Yes', please describe:

   _____

   _____

   a. Can this be corrected or compensated for? ☐ Yes ☐ No ☐ NA
3. In your opinion, does this person have sufficient vision to safely operate a motor vehicle? ☐ Yes ☐ No

   a. If yes, should any restrictions be imposed? ☐ Yes ☐ No If 'Yes', please check the applicable restriction(s) below:

**Restriction Code/Description**

| | | | |
|---|---|---|---|
| ☐ | 1 | - | Bioptic lenses required |
| ☐ | B | - | Corrective lenses required (**For Driving**) |
| ☐ | G | - | Daylight hours only (if difficulty seeing in dim light or at night) |
| ☐ | F | - | Right exterior mirror required |
| ☐ | I | - | Left exterior mirror required |
| ☐ | R | - | No Highway/Interstate |
| ☐ | Other | - | Please explain |

_____

**PHYSICIAN ACKNOWLEDGEMENT**

I, _____, being licensed to practice optometry/ophthalmology, certify that I have personally examined the vision of the above-named individual, that a true record of this examination appears on this report and that he or she signed this form in my presence.

Name of Practice _____

Physician Full Name: Last: _____ First: _____ M.I. _____

Specialty: _____

License Number/State _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ - _____ - _____

_____ _____

**Physician Signature** **Date**

# Drivers License Advisory Board



- The DDS Drivers License Advisory Board (DLAB) counsels DDS on medical issues relating to driver's licenses and provides assistance to the Medical Review Unit in complex cases by rendering a medical opinion based on legal requirements.
- Appointed DLAB physicians are Georgia Board Certified and specialize in the following areas:
  - Internal Medicine
  - Neurology
  - Orthopedic Medicine
  - Cardiology
  - Endocrinology
  - Geriatric Medicine
  - Psychiatry
  - Ophthalmology
  - Pulmonology
- DLAB physicians serve on the Board for a 4-year term.

# Medical Review Types

- Type 79: Alteration of Consciousness – (Non-Specific Revocation)
  - One year from last episode
- Type 80: Epilepsy Revocation
  - 6 Months from last episode
- Type 81: Emergency Revocation
  - Immediate revocation
- Type 91: Physical/Mental Disability Revocation
  - All general medical and vision
- Type 95: Bioptic Lense Cancellation
  - Bioptic only

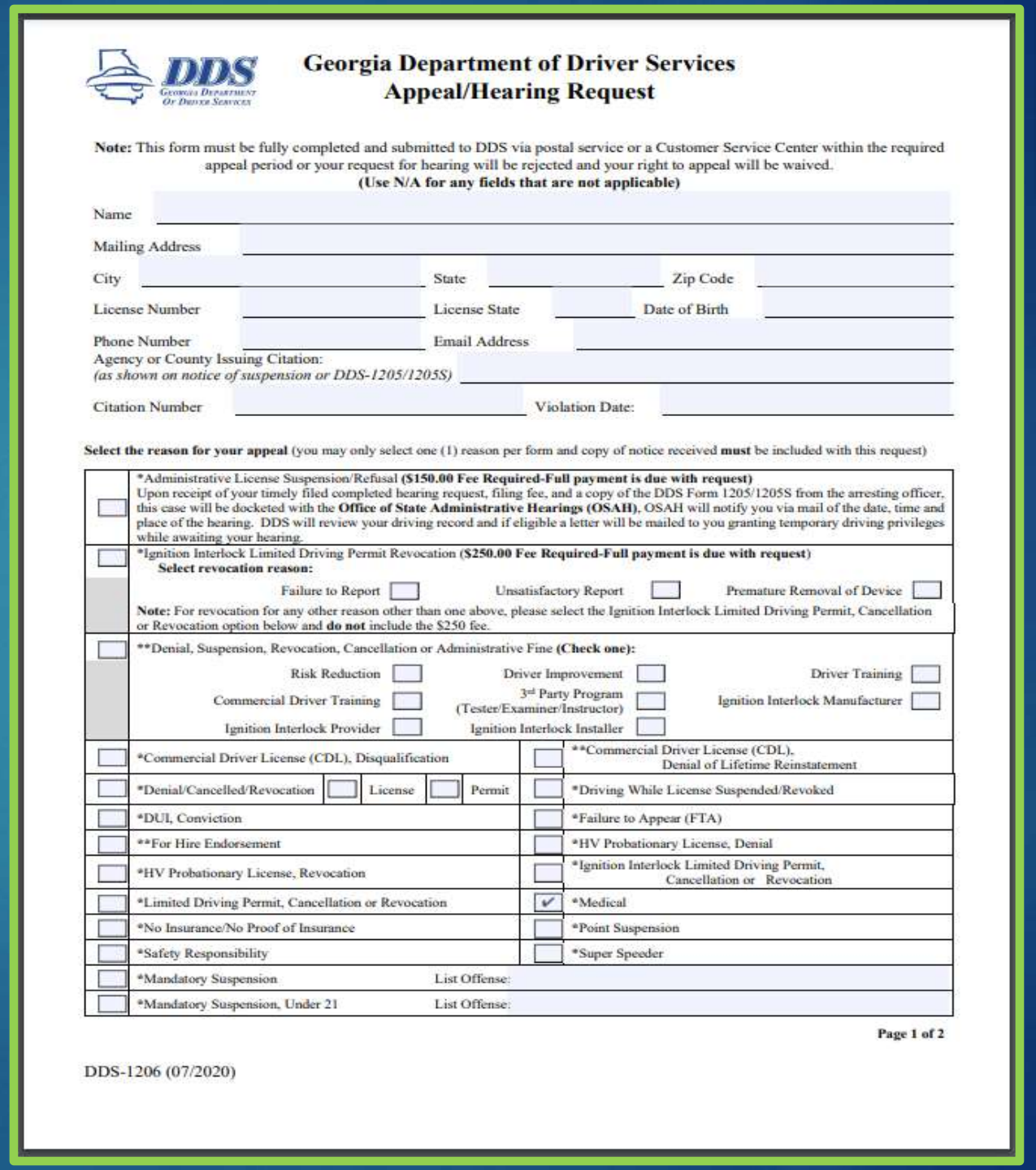
# DDS Appeal Process



- In accordance with the Georgia Administrative Procedure Act, a person determined unqualified to be licensed may request a hearing of his/her case before an Administrative Law Judge of the Office of State Administrative Hearings (OSAH).
- The purpose of the hearing is to determine the person's competency to safely operate a motor vehicle.
- A Hearing Request must be made by submitting the required DDS-1206 form within 15 days of receiving the Official Notice of Revocation. (O.C.G.A. § 40-5-35)
  - If the Hearing Request is not submitted within the 15-day period, any rights to an appeal and hearing will be considered waived and the revocation stands.
  - If the Hearing Request is submitted, Medical Review will escalate the case to DDS Legal to have it scheduled for a hearing before an OSAH judge.
- Appeals are held in accordance with Ga. Admin. Comp. Ch. 375-3-3-.04.

# HEARING REQUEST DDS-1206 Page 1 of 2





DDS
Georgia Department of Driver Services

## Georgia Department of Driver Services
## Appeal/Hearing Request

**Note:** This form must be fully completed and submitted to DDS via postal service or a Customer Service Center within the required appeal period or your request for hearing will be rejected and your right to appeal will be waived.
**(Use N/A for any fields that are not applicable)**

Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

License Number _____ License State _____ Date of Birth _____

Phone Number _____ Email Address _____

Agency or County Issuing Citation:
*(as shown on notice of suspension or DDS-1205/1205S)* _____

Citation Number _____ Violation Date: _____

**Select the reason for your appeal** (you may only select one (1) reason per form and copy of notice received **must** be included with this request)

☐ *Administrative License Suspension/Refusal **($150.00 Fee Required-Full payment is due with request)**
Upon receipt of your timely filed completed hearing request, filing fee, and a copy of the DDS Form 1205/1205S from the arresting officer, this case will be docketed with the **Office of State Administrative Hearings (OSAH)**, OSAH will notify you via mail of the date, time and place of the hearing. DDS will review your driving record and if eligible a letter will be mailed to you granting temporary driving privileges while awaiting your hearing.

☐ *Ignition Interlock Limited Driving Permit Revocation **($250.00 Fee Required-Full payment is due with request)**
**Select revocation reason:**
Failure to Report ☐ Unsatisfactory Report ☐ Premature Removal of Device ☐
**Note:** For revocation for any other reason other than one above, please select the Ignition Interlock Limited Driving Permit, Cancellation or Revocation option below and **do not** include the $250 fee.

☐ **Denial, Suspension, Revocation, Cancellation or Administrative Fine **(Check one):**
Risk Reduction ☐ Driver Improvement ☐ Driver Training ☐
Commercial Driver Training ☐ 3rd Party Program (Tester/Examiner/Instructor) ☐ Ignition Interlock Manufacturer ☐
Ignition Interlock Provider ☐ Ignition Interlock Installer ☐

| | | | |
|---|---|---|---|
| ☐ | *Commercial Driver License (CDL), Disqualification | ☐ | **Commercial Driver License (CDL), Denial of Lifetime Reinstatement |
| ☐ | *Denial/Cancelled/Revocation ☐ License ☐ Permit | ☐ | *Driving While License Suspended/Revoked |
| ☐ | *DUI, Conviction | ☐ | *Failure to Appear (FTA) |
| ☐ | **For Hire Endorsement | ☐ | *HV Probationary License, Denial |
| ☐ | *HV Probationary License, Revocation | ☐ | *Ignition Interlock Limited Driving Permit, Cancellation or Revocation |
| ☐ | *Limited Driving Permit, Cancellation or Revocation | ☑ | *Medical |
| ☐ | *No Insurance/No Proof of Insurance | ☐ | *Point Suspension |
| ☐ | *Safety Responsibility | ☐ | *Super Speeder |
| ☐ | *Mandatory Suspension List Offense: | | |
| ☐ | *Mandatory Suspension, Under 21 List Offense: | | |



DDS-1206 (07/2020)

# HEARING REQUEST DDS-1206 Page 2 of 2



Name of Attorney: (if applicable) _____ Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please cite the legal authority under which the appeal is filed, including all code sections:

Statement describing how in taking such action, DDS failed to act in accordance with the law:

Prayer for Relief/Desired Outcome:

Customer's Signature _____ Date _____

Attorney's Signature *(if applicable)* _____ Date _____

**Please ensure your form is sent to the correct address below based on your reason for appeal:**
(The asterisk(s)* next to the reason for appeal should match the asterisk(s) next to the addresses below)

***Records Management**
Georgia Department of Driver Services
RM-Hearing Requests
P.O. Box 80447
Conyers, GA 30013

****Regulatory Compliance**
Georgia Department of Driver Services
Attn: Regulatory Compliance Division
2206 Eastview Parkway
Conyers, GA 30013

**FOR DEPARTMENTAL USE ONLY**

| Team Member Name | | Location | | Date | |
|---|---|---|---|---|---|

DDS-1206 (07/2020)

# Emergency Revocation

- O.C.G.A. § 40-5-59
- The department authorized to revoke the license of a driver without a preliminary examination or hearing
  - Recommendation from Court or prosecutor
  - Should indicate whether the person has been given notice of recommendation of revocation to DDS
  - record that driver is medically, physically, mentally incapacitated
- After revocation driver will be allowed to request a hearing or make a showing that he or she is competent to operate a motor vehicle

# DDS Contact Information

WEBSITE: www.dds.georgia.gov

DDS CALL CENTER: 678-413-8400

MEDICAL REVIEW UNIT: 678-413-8760

MEDICAL REVIEW FAX: 770-344-3629

LICENSE STATUS CHECK: 404-657-9300*

*VALID ONLY FOR LICENSES ISSUED BY THE STATE OF GEORGIA

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GeorgiaDDS

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# Questions