

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: Formal Notification of Driving Restrictions

Dear [Patient Name],

This letter serves as formal documentation regarding your medical fitness to operate a motor vehicle. Based on your recent clinical evaluation on [Date of Evaluation] and a review of your current medical condition, specifically [Medical Condition/Diagnosis], I am advising you of the following restrictions.

Current Status:

You are medically cleared to drive with no restrictions.

You are medically cleared to drive with the following modifications: [e.g., daytime only, within 10 miles].

You are **NOT** medically cleared to operate a motor vehicle at this time.

Reason for Restriction:

[Insert brief explanation, e.g., risk of sudden loss of consciousness, impaired vision, medication side effects, or cognitive impairment].

Duration of Restriction:

These restrictions are in effect until [Date] or until you have been cleared by this office following a follow-up assessment.

Please be advised that as your healthcare provider, I have a professional responsibility to prioritize your safety and the safety of the public. Failure to comply with these restrictions may result in legal or insurance liabilities. In accordance with state law, our office [may be / has been] required to report these findings to the Department of Motor Vehicles (DMV).

We will re-evaluate your status on [Date of Next Appointment]. If you have any questions regarding these restrictions, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Printed Name]

[Practice/Clinic Name]