



Georgia Department of Driver Services

Mechanical Aid Form

Instructions: Complete the "Driver/Patient Section" below. After completing the "Driver/Patient Section," have your Healthcare provider (e.g. Physician, Occupational Therapist) complete and sign the form. The form must be submitted by the Healthcare provider to the Medical Review unit by fax (770-344-3629) or email (medrevinfo@dds.ga.gov).

Driver/Patient Section														
Last Name:	First Name:	Middle Initial												
Mailing Address:	City/ State/Zip	Phone Number:												
Driver License or Permit Number	Date of Birth:													
<p style="text-align: center;">Please select devices and/ or restrictions that apply:</p> <table><tbody><tr><td>Hand Controls</td><td>No Highway/ Interstate</td></tr><tr><td>Left Accelerator</td><td>Daylight Driving Only</td></tr><tr><td>Left Exterior Mirror</td><td>Corrective Lenses</td></tr><tr><td>Right Exterior Mirror</td><td>Bioptic Lenses</td></tr><tr><td>Automatic Transmission</td><td>Prosthetic Aids</td></tr><tr><td>Power Brakes/ Steering</td><td>Other: _____</td></tr></tbody></table> <p style="text-align: center;">Please provide reason for devices and restrictions:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			Hand Controls	No Highway/ Interstate	Left Accelerator	Daylight Driving Only	Left Exterior Mirror	Corrective Lenses	Right Exterior Mirror	Bioptic Lenses	Automatic Transmission	Prosthetic Aids	Power Brakes/ Steering	Other: _____
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Power Brakes/ Steering	Other: _____													
Healthcare Provider														
Full Name(Please Print)	Medical License Number/ Specialty													
Mailing Address:	City/ State/Zip Code	Phone Number:												

Physician/ Healthcare Provider's Signature:

Date:

Driver's Signature:

Date: