Florida Department of Highway Safety and Motor Vehicle

ALCOHOL/DRUG USAGE QUESTIONNAIRE

Please have this form completed by your counselor or treatment source.

NAME: _____ DATE OF BIRTH: _____ DATE: _____

DRIVER LICENSE#: _____ TELEPHONE #: _____

1. Please provide a brief history of this individual's alcohol and/or drug usage:

_____

_____

_____

2. Has this individual participated in an alcohol/drug treatment program?

   Yes _____ Where? _____

   Length of time in treatment: _____

   Date of admission/discharge: _____

   Comments: _____

   No _____

3. Is the individual currently participating in an aftercare program? _____

   How frequently? _____

4. How long have you known this individual? _____

   Frequency of contact? _____

5. To the best of your knowledge, how long has this individual been alcohol/drug free?

   _____

6. Do you feel this individual would be capable of operating a motor vehicle safely?

   Yes _____ No _____

   Comments:

   _____

   _____

   _____

WHEN THIS FORM IS COMPLETE,
PLEASE MAIL DIRECTLY TO:
Bureau of Motorist Compliance
***Attn: Medical* Review Section**
Neil Kirkman Building, MS 86
Tallahassee, Florida 32399-0570
Telephone No. (850) 617-3814

_____
Please Print Name

_____
Signature

_____
Position/Relationship

_____
Telephone Number

_____
Date

HSMV 72480 (Rev. 06/11)