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

HSMV 72480 (Rev. 06/11)

Please Print Name

Signature

Position/Relationship

Telephone Number

Date