UNITED COMMUNITY ACTION PARTNERSHIP

Volunteer Driver Transportation Program
Medical Statement

_______________________________ has no known medical condition which would interfere with safe driving of a vehicle.

(Volunteer's name)

_________ I have reviewed the above listed individual's medications with him/her, and he/she **may** drive while taking these medications.

_________ I have reviewed the above listed individual's medications with him/her, and he/she **may NOT** drive while taking these medications.

*Please attach a current list of medications.

Additional Comments:

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_______________________________ _______________________________

Physician's Signature **Date**

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Name and Address of Physician's Office