



UNITED COMMUNITY ACTION PARTNERSHIP

Transportation Program Volunteer Driver 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:

Physician's Signature

Date

Name and Address of Physician's Office