Reset

OPIATE PRESCRIPTION VERIFICATION FORM

Office of the Secretary of State
DEPARTMENT OF ADMINISTRATIVE HEARINGS
Mail this form to:
Secretary of State
Department of Administrative Hearings
Support Services Section
501 S. 2nd St., Room 212, Howlett Building
Springfield, IL 62756
Phone: 217-782-7065
ilsos.gov

TO BE COMPLETED BY THE PETITIONER:

Petitioner (please print): _____

Driver's License No.: _____

I, the undersigned, hereby affirm that my physician has prescribed an opiate medication and that the following is correct:

(1) My physician recommended an opiate medication for pain management.

(2) Please check as appropriate:

☐ I am stable while using the prescription opiate medication.

☐ While I have prescription for an opiate medication, as of the date below, I have not used any opiate medication.

_____ _____
Petitioner's Signature Signature Date

TO BE COMPLETED BY THE PHYSICIAN'S OFFICE:

Physician's Name (please print): _____

Physician's Address: _____

_____

Physician's Telephone: _____

Medical License Number/Specialty: _____

I, the undersigned, hereby affirm that I am the Petitioner's physician who recommended an opiate medication for pain management and the following is correct:

(1) The Petitioner has been stable on the prescription opiate medication since _____.

(2) The Petitioner's use of a prescription opiate medication will not affect their ability to drive safely in the future.

_____ _____
Physician's Signature Signature Date

TO BE COMPLETED BY THE PRIMARY SUBSTANCE ABUSE/ALCOHOLISM TREATMENT PROVIDER:
(This section must be completed only after completion of the first two sections.)

Counselor's Name (please print): _____

Agency's Name: _____

Agency's Address: _____

_____

Agency's Telephone: _____

Counselor's Treatment License #: _____

I, the undersigned, hereby affirm that I am the Petitioner's primary treatment provider and I am fully aware of the contents of the instant form and that the following is correct:

(1) The Petitioner is currently classified by the evaluator as _____.

(2) The Petitioner has successfully completed all treatment requirements and is not in need of further treatment.

(3) The Petitioner's use of prescription opiate medication will not affect their prognosis of alcohol-related arrests and Petitioner's prognosis remains _____.

_____ _____
Counselor's Signature Signature Date

PLEASE NOTE THE FOLLOWING:

If the Petitioner is currently using a prescription opiate medication at the time of the hearing, the completed form must be submitted at the time of hearing or the case will be continued in order to obtain this form.

All driving relief is contingent upon submission of said form at the hearing and failure to report use of any prescription pain medication at the time of the hearing will result in denial of driving relief, unless the hearing officer reopens the record to submit this form.

Only Petitioners generally classified High Risk Dependent and who have been specifically diagnosed as Opiate Dependent must demonstrate at least six months of stable use of prescription opiate medication prior to the date of the hearing to obtain a Restricted Driving permit and 12 months of stable use of prescription opiate medication prior to the date of the hearing to obtain reinstatement of driving privileges.