Medical Examination Report

☐ DOT Physical Exam ☐ NON-DOT Physical Exam

1. APPLICANT'S INFORMATION

Applicant completes this section.

Applicant's Name (Last, First, Middle)	Social Security Number	Birth Date	Age	Gender	☐ New certification ☐ Recertification ☐ Follow Up	Date of Exam

Address	City, State, Zip Code	Work Phone: / Home Phone:	Driver License No.	License Class	State of Issue
				☐ A ☐ C ☐ B ☐ D ☐ Other	

2. HEALTH HISTORY

Applicant completes this section, but medical examiner is encouraged to discuss with applicant.

Yes	No		Yes	No	
☐	☐	Any illness or injury in last 5 years?	☐	☐	Liver disease
☐	☐	Head/Brain injuries, disorders or illnesses	☐	☐	Digestive problems
☐	☐	Seizures, epilepsy medication:	☐	☐	Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin
☐	☐	Eye disorders or impaired vision (except corrective lenses)	☐	☐	Nervous or psychiatric disorders, e.g., severe depression medication:
☐	☐	Ear disorders, loss of hearing or balance	☐	☐	Loss of, or altered consciousness
☐	☐	Heart disease or heart attack; other cardiovascular condition medication:	☐	☐	Fainting, dizziness
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	High blood pressure medication:	☐	☐	Stroke or paralysis
			☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Muscular disease	☐	☐	Spinal injury or disease
☐	☐	Shortness of breath	☐	☐	Chronic low back pain
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis	☐	☐	Regular, frequent alcohol use
☐	☐	Kidney disease, dialysis	☐	☐	Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

_____ _____

Applicant's Signature **Date**

Medical Examiners Comments on Health History

(The medical examiner must review and discuss with the applicant any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving.)

INSTRUCTIONS: The presence of a certain condition may not necessarily disqualify an applicant, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify an applicant, the medical examiner may consider deferring the applicant temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving. Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail, and indicate whether it would affect the applicant's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See Instructions to the Medical Examiner for guidance.

TESTING (Medical Examiner completes Section 3 through 7)

3. VISION — **Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.**

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. ***Monocular drivers are not qualified.***

	Acuity Uncorrected	Acuity Corrected	Horizontal Field of Vision
Right Eye	20/	20/	degrees
Left Eye	20/	20/	degrees
Both Eyes	20/	20/	

	Yes	No
Applicant can recognize and distinguish among traffic control /signals and devices showing standard red, green, and amber colors.	☐	☐
Applicant meets visual acuity requirement only when wearing corrective lenses.	☐	☐
Applicant only has monocular vision.	☐	☐

Complete next line only if vision testing is done by an opthalmologist or optometrist.

Date of Examination	Name of Ophthalmologist or Optometrist (print)	Telephone Number	License No./ State of Issue	Signature

4. HEARING — **Standard: a) Must first perceive forced whispered voice >= 5 ft., with or without hearing aid, or b) average hearing loss in better ear <= 40 dB.** ☐ **Check if hearing aid used for tests.** ☐ **Check if hearing aid required to meet standard.**

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear	Left Ear
	feet	feet

b) If audiometer is used, record hearing loss in decibels. (according to ANSI Z24.5-1951)	Right Ear			Left Ear		
	500	1000	2000	500	1000	2000
Average						

5. BLOOD PRESSURE/ PULSE RATE — **Standard: Applicant qualified if 140/90 or less. Medical Examiner should take at least two readings to confirm BP.**

Blood Pressure Systolic	Blood Pressure Diastolic	Reading	Category	Expiration Date	Recertification
		140-159/90-99	Stage 1	Certified for one year	1 year if 140/90 or less. One-time certificate for 3 months if 141-159/91-99.
		160-179/100-109	Stage 2	One time certificate for three months	1 year from date of exam if 140/90 or less.
		180/110 or greater	Stage 3	6 months from date of exam if <140/90	6 months if 140/90 or less.

Pulse

Rate	☐ Regular ☐ Irregular

6. LABORATORY AND OTHER TEST FINDINGS — **Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.**

	Specific Gravity	Protein	Blood	Sugar
Urinalysis				

Other Testing *(Describe and record)*

7. VITALS — **Height:** **Weight:** **FSBS:** **BMI:** **ESS:**

8. PHYSICAL EXAMINATION

BODY SYSTEM	CHECK FOR	YES NO	BODY SYSTEM	CHECK FOR	YES NO
General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	☐ ☐	**Abdomen and Viscera**	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.	☐ ☐
Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.	☐ ☐	**Vascular system**	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.	☐ ☐
			GU System	Hernias.	☐ ☐
Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.	☐ ☐	**Neurological**	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.	☐ ☐
Mouth	Irremediable deformities likely to interfere with breathing or swallowing.	☐ ☐	**Spine, other musculoskeletal**	Previous surgery, deformities, limitation of motion, tenderness.	☐ ☐
Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	☐ ☐	**Extremities – Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.**	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.	☐ ☐
Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or xray of chest.	☐ ☐			

Comments:

Medical Examiner Signature: _____ **Date:** _____

DOT EXAM

Note certification status here.

See *Instructions to the Medical Examiner* for guidance.

- ☐ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
- ☐ Does not meet standards
- ☐ Temporarily disqualified due to (condition or medication)
- ☐ Meets standards, but periodic evaluation required.

Due to _____ applicant qualified only for:

☐ 3 months ☐ 6 months ☐ 1 year ☐ Other: _____

Follow up _____

_____

_____

Expiration date: _____

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____ waiver/exemption. Driver must present exemption at time of certification.
- ☐ Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt intracity zone (See 49 CFR 391.62)
- ☐ Qualified by operation of 49 CFR 391.64

MEDICAL CERTIFIER

Signature: _____

Name (print): _____

Address: _____

City, St, Zip: _____

Telephone: _____

If meets standards, complete a Medical Examiner's Certificate according to 49 CFR 391.43 (h).
(Driver must carry certificate when operating a commercial vehicle.)

NON DOT EXAM

Non-DOT Medical Examination Results

General Physical Examination Conclusions: ☐ Satisfactory ☐ Pending ☐ Rejection Cause for Rejection _____

I certify that I have answered all of the above questions, that I have carefully considered my answers, and that I have disclosed all of the information completely and accurately as requested by the medical examiner for answers to the above questions.

SIGNATURE OF APPLICANT: _____

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly and is on file in my office

PLEASE PRINT NAME AND ADDRESS OF MEDICAL EXAMINER

SIGNATURE OF EXAMINER: _____