

# Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

<b>1. DRIVER'S INFORMATION</b> <small>Driver completes this section</small>						
Driver's Name (Last, First, Middle)	Social Security No.	Birthdate <small>M / D / Y</small>	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	New Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Follow-up <input type="checkbox"/>	Date of Exam
Address	City, State, Zip Code	Work Tel: ( )  Home Tel: ( )	Driver License No.	License Class <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> Other	State of Issue	

**2. HEALTH HISTORY** Driver completes this section, but medical examiner is encouraged to discuss with driver.

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

Driver's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medical Examiner's Comments on Health History** (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below. )

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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.**

**Numerical readings must be provided.**

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/	Right Eye <input type="checkbox"/>
Left Eye	20/	20/	Left Eye <input type="checkbox"/>
Both Eyes	20/	20/	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors?  Yes  No

Applicant meets visual acuity requirement only when wearing:

Corrective Lenses

Monocular Vision:  Yes  No

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

Date of Examination \_\_\_\_\_ Name of Ophthalmologist or Optometrist (print) \_\_\_\_\_ Tel. No. \_\_\_\_\_ License No./ State of Issue \_\_\_\_\_ Signature \_\_\_\_\_

**4. HEARING**

**Standard: a) Must first perceive forced whispered voice  $\geq$  5 ft., with or without hearing aid, or b) average hearing loss in better ear  $\leq$  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.

**Numerical readings must be recorded.**

a) Record distance from individual at which forced whispered voice can first be heard.	Right ear \ Feet	Left Ear \ Feet
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b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI Z24.5-1951)

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average:			Average:		

**5. BLOOD PRESSURE/ PULSE RATE**

**Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.**

Blood Pressure	Systolic	Diastolic
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Driver qualified if  $\leq$ 140/90.

Pulse Rate:  Regular  Irregular

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if $\leq$ 140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if $\leq$ 140/90
$\geq$ 180/110	Stage 3	6 months from date of exam if $\leq$ 140/90	6 months if $\leq$ 140/90

**6. LABORATORY AND OTHER TEST FINDINGS**

**Numerical readings must be recorded.**

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR
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Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other Testing (Describe and record) \_\_\_\_\_

**7. PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ (in.) Weight: \_\_\_\_\_ (lbs.)

Name: Last, First, Middle,

The presence of a certain condition may not necessarily disqualify a driver, 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 a driver, the medical examiner may consider deferring the driver 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 in the space below, and indicate whether it would affect the driver'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.

BODY SYSTEM	CHECK FOR:	YES*	NO	BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.			7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		
2. 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.			8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.			9. Genito-urinary System	Hernias.		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.			10. 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.		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.			11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
6. 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.			12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		

**\*COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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
- Meets standards, but periodic monitoring required due to \_\_\_\_\_  
 Driver qualified only for:  3 months  6 months  1 year  Other

Temporarily disqualified due to (condition or medication): \_\_\_\_\_

Return to medical examiner's office for follow up on \_\_\_\_\_

- Wearing corrective lense
- 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 Examiner's signature \_\_\_\_\_

Medical Examiner's name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

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

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined \_\_\_\_\_ In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- |  |  |
|--|--|
| <input type="checkbox"/> wearing corrective lenses               | <input type="checkbox"/> driving within an exempt intracity zone (49 CFR 391.62)         |
| <input type="checkbox"/> wearing hearing aid                     | <input type="checkbox"/> accompanied by a Skill Performance Evaluation Certificate (SPE) |
| <input type="checkbox"/> accompanied by a _____ waiver exemption | <input type="checkbox"/> Qualified by operation of 49 CFR 391.64                         |

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.

SIGNATURE OF MEDICAL EXAMINER		TELEPHONE	DATE
MEDICAL EXAMINER'S NAME (PRINT)		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Practice Nurse	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE			
SIGNATURE OF DRIVER		DRIVER'S LICENSE NO.	STATE
ADDRESS OF DRIVER			
MEDICAL CERTIFICATE EXPIRATION DATE			