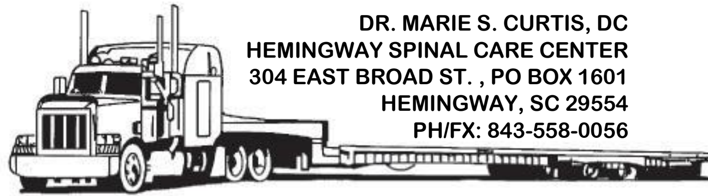

DOT CLEARANCE FOR: CARDIOVASCULAR CONDITIONS

Please inquire with your treating provider's office; an office visit may be required for the completion of this form.

____ ______________________
Patient Name DOB

Dear Provider:

DOT Regulation Section 391.41(b)(4) states "A person is physically qualified to drive a commercial motor vehicle if that person: Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse or congestive cardiac failure".

Before the patient can be cleared for driving a commercial motor vehicle, we need you to verify this person's cardiovascular condition and provide us with appropriate documentation. You are not being asked to make the final determination, just a clinical opinion about the patient's ability to safely operate a commercial vehicle.

Statement of Personal Physician/Provider/Cardiologist.

I have read and understand the DOT regulations cited above. I ☐ VERIFY ☐ DO NOT VERIFY the driver named above has no current/uncontrolled clinical diagnosis of acute myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or significant peripheral vascular disease. He/she has had no recent syncope, dyspnea, collapse, or congestive heart failure. He/she is hemodynamically stable and in no imminent risk of syncopal episodes or other symptoms that would affect his/her ability to safely operate a commercial motor vehicle. He/she has had an Exercise Treadmill Stress Test or equivalent within the last 2 years achieving at least 6 Metabolic Equivalents. He/she has a documented Myocardial Ejection Fraction of at least 40% and demonstrates no intolerance to their cardiovascular medications. Please attach documentation to support this statement.

Do you feel the patient is safe to drive a commercial motor vehicle in regard to his/her Cardiovascular Condition?

☐ Yes ☐ No If yes, please explain____

____

Date of Exam	Provider Name (type)	Provider Signature
Telephone#	License#	State of issue
Address	City / State	Zip

THANK YOU FOR ASSISTING YOUR PATIENT.

*Please fax or have patient deliver this form and any additional relevant information.