DOT Medical Clearance: TYPE 2 DIABETES MELLITUS

DOT Physical Exam Medical Clearance

Patient _____

Date _____

DOB _____

The above driver has presented for a DOT medical certificate to drive a commercial motor vehicle. Per Federal Motor Carrier Safety Administration medical guidelines for drivers with a history of **TYPE 2 DIABETES MELLITUS**, we ask for your professional opinion to determine if the driver is medically cleared to operate a commercial vehicle:

1. Has your patient been on a stable diabetes regimen in the last 3 months? Yes __ No__

2. List all Diabetes-related medications, dosage and date treatment initiated. (*Attach additional pages if necessary*)

   _____

   _____

   _____

3. Copy of the driver's HgbA1C level within the last 3 months attached? Yes __ No ____

4. Does your patient have a history of severe hypoglycemic episodes? (*The FMCSA defines a severe hypoglycemic episode as an episode resulting in impaired cognitive function that occurred without warning, loss of consciousness, seizures or coma, requiring the assistance of others or needing urgent treatment*). Yes __ No__

   If yes, please attach description of the nature of event(s) and date:

5. Does the patient have any of the following complications from his/her diabetes?

   ____Nephropathy ____Retinopathy ____Neuropathy ____Heart Disease

   If yes, please attach relevant reports/medical records/consultation

The demands of a commercial driver include loading/unloading heavy cargo, tarping trailers, coupling/uncoupling trailers, inspecting brake lines and putting on tire chains and require perceptual skills to monitor a complex driving situation and judgment skills to make quick decisions in addition to the ability to control an oversize steering wheel, shift gears using a manual transmission, maneuver a vehicle in crowded areas, enter and exit the cab frequently, and the ability to climb ladders on the tractor/trailer.

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If your recommendation is that the driver can operate a CMV safely, please sign and date below.

_____ _____

Provider's Signature ***Date***

*If it is your recommendation that the driver **cannot** operate a CMV safely, please sign and date below.*

_____ _____

Provider's Signature ***Date***

PRINT PROVIDER'S NAME _____

Address (City, State, Zip): _____

Please return this letter to our office by fax or email to:

_____

Thank you for your assistance.