DOT CLEARANCE FOR: EPILEPSY

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:

FMCSA regulations CFR 391.41 (b)(8) state " A person is physically qualified to drive a commercial motor vehicle if that person: Has no current established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a motor vehicle. The following drivers cannot be qualified: (1) a driver who has a medical history of epilepsy, (2) a driver who has a current clinical diagnosis of epilepsy, or (3) a driver who is taking anti-seizure medication." FMCSA guidelines do not allow for possible exceptions to these requirements.

Before the patient can be cleared for driving a commercial motor vehicle, we need you to verify this person's medical history of seizures/epilepsy 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.

PRIVATE PHYSICIAN STATEMENT

I have read and understand the FMCSA reg cited above. I ☐ VERIFY ☐ DO NOT VERIFY the above noted individual has no medical history of seizures/epilepsy, has no clinical diagnosis of epilepsy and is not taking antiseizure medication that would prohibit him/her to safely operate a commercial motor vehicle. Applicable documentation to support this statement is attached.

Last Seizure Date ___________________ **Date of Last Seizure Medication _________________________________**

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

☐ Yes ☐ No If yes, please explain ____

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Date of Exam **Provider Name (Print)** **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.*