OSCAR MEDICAL CENTER DOT REGISTRATION

Date: _____ Interstate _____ Intrastate _____

Driver's License # _____ New certification___ Recertification_____ Follow-up____

State of issue?_____ License Class: A__ B__ C__ D__ OTHER__

Last Name_____ First Name_____ Middle _____

Address_____ APT_____

City_____ State_____ Zip_____

Cell phone#_____ Email _____ Sex: M___ F___

Date of Birth_____ Age _____ SS# _____

Please answer. Circle YES or NO

	Initial Here
Do you wear glasses? YES NO	
Have you been diagnosed with Diabetes? YES NO	
Do you any physical or mental disorders with Associated Harmful Behavior YES NO	
Are you a problem drinker or an alcoholic? YES NO	
Have you ever used street drugs? YES NO	
Have you ever been diagnosed with Hypertention? YES NO	
Have you been diagnosed with Sleep Apnea? YES NO	
Do you currently use any form of tobacco? YES NO	

DO NOT WRITE BELOW THIS LINE. FOR DOCTOR'S USE ONLY.

General Appearance_____

Height _____ Weight _____ Blood Pressure _____

Respirations_____Temp_____Pulse_____ Neck Circ _____

Rhythm_____ EENT_____

Glandular & Lymphatic System_____

Respiratory System_____

Cardiovascular System_____

Abdomen_____

Neurological_____

Previous Surgery_____

Acuity Test results: R _____ L _____ B _____

Certification: 3 mos | 6 mos | 1 year | 2 years Reason: _____

DOCTORS SIGNATURE: _____

DATE OF EXAM: _____