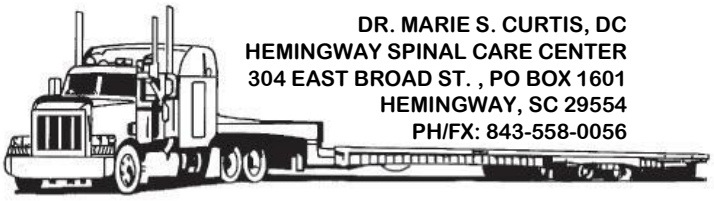

DR. MARIE S. CURTIS, DC
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PH/FX: 843-558-0056

DOT CLEARANCE FOR: COUMADIN THERAPY

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:

History obtained revealed that this individual is currently receiving COUMADIN THERAPY. In accordance with DOT REG 49 CFR 391.41, A driver on Coumadin should be educated about the potential interactions of Coumadin with other medications and diet, the increased risk of bleeding with trauma and the need for regular monitoring of Coumadin's effect. Medical certification of commercial drivers with cerebrovascular disease and who are on Coumadin is not recommended because of the increased risk of intracranial hemorrhage with sudden loss of consciousness.

Personal Physician Statement

I have read and understand the DOT guidelines cited above. I ☐ VERIFY ☐ DO NOT VERIFY that the above named individual has been educated about the potential interactions of Coumadin with other medications and diet, the increased risk of bleeding with trauma and the need for regular monitoring of Coumadin's effect. Also the condition and medications at the clinical dose will not cause imminent risk of a syncopal episode or other symptoms that would affect the individual's ability to safely operate a commercial motor vehicle. I am enclosing appropriate documentation, if applicable, to support this statement.

Please include a copy of patient's last 3 INR values _____ _____ _____

Diagnosis why on Coumadin: DVT, PE, Heart Attack, Heart Surgery, A fib, Stroke etc. _____

_____

Current Treatment & Stability: _____

_____

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

☐ Yes ☐ No If yes, please explain _____

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.