Service Date:
Patient Name:
SSN:

# Medical Examination Report
## FOR COMMERCIAL DRIVER FITNESS DETERMINATION

### 1. DRIVER'S INFORMATION
Driver completes this section

Date of Exam

| Driver's Name (Last, First, Middle) | Social Security No. | Birth Date | Age | Sex | | License Class |
|---|---|---|---|---|---|---|
| | | | | ☐ Male ☐ Female | ☐ New Certification ☐ Recertification ☐ Follow Up | ☐ A ☐ B ☐ C ☐ D ☐ Other ☐ CDL ☐ Intrastate Only |

| Address: | City, State, ZIP Code | Work Tel: Home Tel: | Driver's License No. | State of Issue |
|---|---|---|---|---|
| | | | | |

### 2. HEALTH HISTORY
Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes No
- ☐ ☐ Any illness or injury in last 5 years?
- ☐ ☐ Head/Brain injuries, disorders or illnesses
- ☐ ☐ Seizures, epilepsy - If Yes, list medications: ______
- ☐ ☐ Eye disorders or impaired vision (except corrective lenses)
- ☐ ☐ Ear disorders, loss of hearing or balance
- ☐ ☐ Heart disease or heart attack; other cardiovascular condition
  If Yes, list medications: ______
- ☐ ☐ Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
- ☐ ☐ High blood pressure - If Yes, list medications: ______
- ☐ ☐ Muscular disease

Yes No
- ☐ ☐ Shortness of breath
- ☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis
- ☐ ☐ Kidney disease, dialysis
- ☐ ☐ Liver disease
- ☐ ☐ Digestive problems
- ☐ ☐ Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin
- ☐ ☐ Nervous or psychiatric disorders, e.g., severe depression
  If Yes, list medications: ______
- ☐ ☐ Loss of, or altered consciousness
- ☐ ☐ Surgery

Yes No
- ☐ ☐ Fainting, dizziness
- ☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
- ☐ ☐ Stroke or paralysis
- ☐ ☐ Missing or impaired hand, arm, foot, leg, finger, toe
- ☐ ☐ Spinal injury or disease
- ☐ ☐ Chronic low back pain
- ☐ ☐ Regular, frequent alcohol use
- ☐ ☐ Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.
I authorize Concentra Health Services Inc., its subsidiaries, divisions and related entities (collectively "Concentra") to provide all or any of my medical records to my employer and release Concentra, its employees, physicians, nurses, technicians and any other employee from any and all liabilities, claims, or causes of action that may result from this authorization.

Driver's Signature ______ Date ______

**Medical Examiner's Comments on Health History** (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

## Testing (Medical Examiner completes Section 3 through 7)

### 3. VISION
**Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.**

**INSTRUCTIONS:** *When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious.* ***Monocular drivers are not qualified.***

**Numerical readings must be provided.**

| ACUITY | UNCORRECTED | CORRECTED | HORIZONTAL FIELD OF VISION | |
|---|---|---|---|---|
| Right Eye | 20/ | 20/ | Right Eye | ° |
| Left Eye | 20/ | 20/ | Left Eye | ° |
| Both Eyes | 20/ | 20/ | | ° |

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing: ☐ Corrective Lenses

Monocular Vision: ☐ Yes ☐ No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination ______ Name of Ophthalmologist or Optometrist (Print) ______ Tel No. ______ License No/State of Issue ______ Signature ______

### 4. HEARING
**Standard: a) Must first perceive forced whispered voice >= 5 ft., with or without hearing aid, or b) average hearing loss in better ear <= 40 dB**
☐ Check if hearing aid used for tests ☐ Check if hearing aid required to meet standard.

**INSTRUCTIONS:** *To convert audiometric test results from ISO to ANSI. -14 dB from ISO for 500Hz, -10 dB for 1,000Hz, -8.5 dB for 2,000HZ. To average, add the readings for 3 frequencies tested and divide by 3.*

**Numerical reading must be recorded.**

| | Right Ear | Left Ear |
|---|---|---|
| a) Record distance from individual at which forced whispered voice can first be heard. | \ Feet | \ Feet |

| b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI Z24.5-1951) | Right Ear | | | Left Ear | | |
|---|---|---|---|---|---|---|
| | 500 Hz | 1000 Hz | 2000 Hz | 500 Hz | 1000 Hz | 2000 Hz |
| | | | | | | |
| | Average: | | | Average: | | |

### 5. BLOOD PRESSURE / PULSE RATE
**Numerical readings must be recorded.** ***Medical examiner should take at least 2 readings to confirm blood pressure.***

| Blood Pressure | Systolic | Diastolic |
|---|---|---|
| | | |

*Driver qualified if <= 140/90.*

Pulse Rate : ☐ Regular ☐ Irregular

Record Pulse Rate:

| Reading | Category | Expiration Date | Recertification |
|---|---|---|---|
| 140-159/90-99 | Stage 1 | 1 year | 1 year if <= 140/90 One-time certificate for 3 months if 141-159/91-99 |
| 160-179/100-109 | Stage 2 | One-time certificate for 3 months | 1 year from date of exam if <= 140/90 |
| >= 180/110 | Stage 3 | Disqualified 6 months from date of exam if <= 140/90 | 6 months if <= 140/90 |

### 6. LABORATORY AND OTHER TEST FINDINGS
**Numerical reading must be recorded.**

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**Urinalysis is required.** Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

| URINE SPECIMEN | SP. GR | PROTEIN | BLOOD | SUGAR |
|---|---|---|---|---|
| | | | | |

Other Testing *(Describe and record)*

## 7. PHYSICAL EXAMINATION Height_________ (in.) Weight (BMI) _________ (lbs)

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for.

See *Instructions To The Medical Examiner for guidance.*

| BODY SYSTEM | CHECK FOR: | YES * | NO |
|---|---|---|---|
| 1. General Appearance | Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse. | | |
| 2. Eyes | Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate. | | |
| 3. Ears | Scarring of tympanic membrane, occlusion of external canal, perforated eardrums. | | |
| 4. Mouth and Throat | Irremediable deformities likely to interfere with breathing or swallowing | | |
| 5. Heart | Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator. | | |
| 6. Lungs and chest, not including breast examination | Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or xray of chest. | | |
| 7. Abdomen and Viscera | Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness. | | |
| 8. Vascular | Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins. | | |
| 9. Genito-urinary | Hernias. | | |
| 10. Extremities - Limb impaired. Driver may be subject to SPE certificate if otherwise qualified. | Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly. | | |
| 11. Spine, other musculoskeletal | Previous surgery, deformities, limitation of motion, tenderness. | | |
| 12. Neurological | Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia. | | |

* COMMENTS: (explain all YES answers):_______________

Note certification status here. See Instructions to the Medical Examiner for guidance.

- ☐ Update to previously transmitted exam
- ☐ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
- ☐ Does not meet standards
- ☐ Meets standards, but periodic evaluation required.
  Due to_______________driver qualified only for:
  ☐ 3 months ☐ 6 months ☐ 1 year
  ☐ Other_______________
- ☐ Temporarily disqualified due to (condition or medication):_______________
  Return to medical examiner's office for follow up on _______________

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _______________waiver/exemption. Driver must present exemption at time of certification. Exemption expanation (if necessary _______________.
- ☐ Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt intracity zone. (See 49 CFR 391.62)
- ☐ Qualified by operation of 49 CFR 391.64

Medical Examiner's Signature_______________
Medical Examiner's Name (print)_______________
Address_______________
Telephone Number_______________

**If meets standards, complete a Medical Examiner's Certificate according to 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)**

## MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined_______________in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- ☐ wearing corrective lenses
- ☐ wearing hearing aid
- ☐ accompanied by a _______________waiver/exemption
- ☐ driving within an exempt intracity zone (49 CFR 391.62)
- ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ Qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

| SIGNATURE OF MEDICAL EXAMINER | | TELEPHONE | | DATE |
|---|---|---|---|---|
| MEDICAL EXAMINER'S NAME (PRINT) | | ☐ MD ☐ DO | ☐ Physician Assistant ☐ Advance Practice Nurse | ☐ Chiropractor ☐ Other Practioner |
| MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. / ISSUING STATE | | NATIONAL REGISTRY NO. | | |
| SIGNATURE OF DRIVER | Intrastate Only ☐ Yes ☐ No | CDL ☐ Yes ☐ No | DRIVER'S LICENSE NO. | STATE |
| ADDRESS OF DRIVER | | | | |
| MEDICAL CERTIFICATE EXPIRATION DATE | | | | |