Ontario Ministry of Transportation

FMCSA Medical Report

Complete this form if you are requesting proof of medical fitness to comply with the Federal Motor Carrier Safety Administration (FMCSA) requirement.

The ministry requires you to have this form completed by a physician or nurse practitioner who has knowledge of your medical condition. Completion of this form may require that your physician or nurse practitioner conduct a medical assessment or use recent information on your medical file that has been obtained within the last 3 months.
To avoid delays in reviewing your form all questions must be completed in full. For additional information, please visit www.mto.gov.on.ca/english/safety/medical-review.shtml.

Fax completed medical report to: 416 235-3400 or 1 800 304-7889. Clearly indicate on the fax cover sheet the following, **"This request is for a Medical Confirmation Letter for a G class licence holder operating in the United States".** You are encouraged to keep a copy of the medical report and fax confirmation for your own records.

Information in this form is collected under the authority of the *Highway Traffic Act*, s. 15, Reg. 340/94, and is used to evaluate fitness to operate a motor vehicle. Direct enquiries to: Ministry of Transportation, Driver Improvement Office, Medical Review Section, 77 Wellesley St. W Box 589, Toronto ON M7A 1N3. Phone: 416 235-1773 or 1 800 268-1481.

Fields marked with an asterisk (*) are mandatory.

Driver Information

Driver's Licence Number*	Date of Birth (yyyy/mm/dd)

Last Name	First Name	Middle Initial

Mailing Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Driver's Certificate and Release of Information

I certify that the foregoing information is to the best of my knowledge correct and agree to this report and any future report from this examination only being given to the Ministry of Transportation.

The cost of any examination and for the completion of this form by your physician or other health care provider is not a benefit of OHIP and not the responsibility of the Ministry of Transportation and must be paid for by the applicant.

Business Telephone Number	Home Telephone Number	Signature	Date (yyyy/mm/dd)

Complete Health History

To be completed in full by examining physician or specialist or Nurse Practitioner. **Yes** answers should be explained on the reverse side under History Details.

1. Diseases of Senses (deafness, vertigo, visual deficiencies, etc.)	☐ Yes	☐ No
2. Cardiovascular Diseases (heart failure, angina, infarction, embolism, arrhythmia, syncope, surgery, etc.)	☐ Yes	☐ No
3. Respiratory Diseases (asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease, etc.)	☐ Yes	☐ No
4. Diseases of the Musculo-Skeletal System (Fracture(s) or Amputation, Arthritis, etc.)	☐ Yes	☐ No
5. Metabolic Diseases (Diabetes (+) (-), Hypoglycemia, Thyroid, etc.)	☐ Yes	☐ No
6. Psychiatric Disorders (Psychoneurosis, Psychosis, etc.)	☐ Yes	☐ No
7. Addictions (Alcohol, Sedatives, Tranquillizers, Narcotics, etc.)	☐ Yes	☐ No
8. Other Diseases (Blackouts, Fainting Spells, Anemia, Cancer, Sleep Disorders, etc.)	☐ Yes	☐ No
9. Neurological Diseases (Seizures, Cerebrovascular Diseases, Parkinson's Disease, Multiple Sclerosis, Dementia, Head Injury, Mental Retardation, etc.)	☐ Yes	☐ No

Date of Most Recent Seizure (yyyy/mm/dd)	Date of Examination (yyyy/mm/dd)

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History Details

1. Eyes

Eye	Acuity without corrective lenses	Acuity with corrective lenses	Horizontal Field of Vision
Right	20/	20/	☐ Normal ☐ Restricted
Left	20/	20/	☐ Normal ☐ Restricted
Both eyes together	20/	20/	☐ Normal ☐ Restricted

2. Hearing

Class B, C, E, F *Highway Traffic Act* standard; Hearing loss in better ear with/without hearing aid, no greater than 40 decibels at 500, 1,000 and 2,000 hertz. Class A, D must meet if operating in U.S; Hearing loss in better ear with/without hearing aid, no greater than 40 decibels averaged at 500, 1,000 and 2,000 hertz

Does hearing meet standards? ☐ Yes ☐ No Are hearing aids required? ☐ Yes ☐ No

3. Heart	Apical Rate	Murmurs	Rhythm	Blood Pressure
4. Locomotor	Upper Extremity	Lower Extremity	Neck and Lumbar	

5. Chest/Abdomen

6. Urinary	Urine Protein	Glucose

7. Diabetes ☐ Yes ☐ No

Type

Treatment ☐ Diet alone ☐ Oral medication - amt per 24hrs. _____

☐ Insulin - amt per 24 hrs. _____

8. Hypoglycemia

Has the patient had a reported episode of severe hypoglycemia requiring outside intervention in the past 6 months? ☐ Yes ☐ No

Loss of Consciousness?		Decrease in cognition, etc.	
9. Neurological	Gait and Stance	Reflexes	Tremor	Coordination

10. Evidence of Emotional Disorder Instability ☐ Yes ☐ No Neurosis ☐ Yes ☐ No Psychosis ☐ Yes ☐ No

11. Addictions. If yes to Q7 on reverse please specify

Period of Abstinence	Alcoholism	Drug Habituation
< 6 months	☐	☐
6 to < 12 months	☐	☐
≥ 12 months	☐	☐

History Details and Summary (additional comments or information to take into consideration e.g. diagnosis, prognosis, treatment, date condition resolved, etc.)

Physician's Signature

☐ Family Physician and/or Treating Physician ☐ Nurse Practitioner ☐ Specialist (Specify) _____

How long has this person been your patient?

Physician/Nurse Practitioner's Name

Last Name	First Name	Middle Initial

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Signature	Date (yyyy/mm/dd)