Department of Family Medicine

HUTCHINSON Clinic

Verlin K. Janzen, MD, FAAFP

Welcome!

To make your appointment for a COMMERCIAL DRIVER FITNESS EXAM as efficient as possible, please follow these instructions:

1) Call 669-2512 to schedule an appointment for "DOT Physical". Be to Dr Janzen's office on time – if you are late or don't have your paperwork completed, your appointment may be rescheduled.

   My appointment is on _____ at _____ am/pm

2) Complete items 1 (Driver's Information) and 2 (Health History) on the Medical Examination Report form that follows BEFORE you come to the office. This includes all information down to and including the Driver's signature and date.

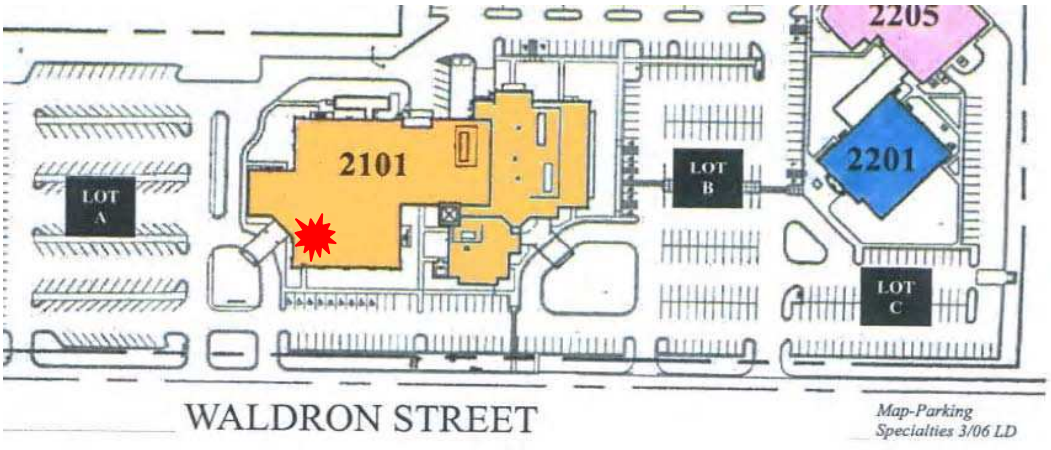
3) Bring this ENTIRE FORM with you to the office.

4) Go to the Hutchinson Clinic Laboratory @ least 20 minutes before your appointment with Dr. Janzen for a urine test (this is not a drug test – it checks for protein and sugar as required by law as part of this exam). Give the Laboratory the "Lab order for urinalysis" order that follows.

5) Bring your driver's license – office staff will check this as part of the evaluation

6) If your employer requires that we send the entire examination to them (this is not required by law), please complete the AUTHORIZATION FOR RELEASE OF INFORMATION (last page)

Dr. Janzen is located in the 2101 Building – enter at the southeast corner by



Department of Family Medicine

HUTCHINSON Clinic

Verlin K. Janzen, MD, FAAFP

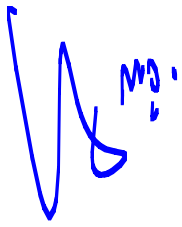
LABORATORY ORDER

Take this to the Hutchinson Clinic Laboratory @ least 30 minutes before your appointment with Dr. Janzen for a urine test. This is NOT a drug test. It is a urine dipstick test required as part of the DOT Medical Examination.

Laboratory Order for: Dipstick Urinalysis

Ordering Physician: Dr. Janzen (101)

Dx: DOT Medical Examination physical



Medical Examination Report
FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

1. DRIVER'S INFORMATION

Driver completes this section

Driver's Name (Last, First, Middle)	Social Security No.	Birthdate M / D / Y	Age	Sex ☐ M ☐ F	New Certification ☐ Recertification ☐ Follow-up ☐	Date of Exam

Address	City, State, Zip Code	Work Tel: ( ) Home Tel: ( )	Driver License No.	License Class ☐ A ☐ B ☐ C ☐ D ☐ Other	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 the last 5 years?
☐	☐	Head/Brain injuries, disorders or illnesses
☐	☐	Seizures, epilepsy ☐ medication_____
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack; other cardiovascular condition ☐ medication_____
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker) ☐
☐	☐	High blood pressure ☐ medication_____
☐	☐	Muscular disease
☐	☐	Shortness of breath

Yes	No	
☐	☐	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 ☐ medication_____
☐	☐	Loss of, or altered consciousness

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.

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) Name: Last, First, Middle,

3. VISION

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees 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 opthalmologist 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, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings 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 two readings to confirm BP.

Blood Pressure	Systolic	Diastolic

Driver qualified if ≤140/90.

Pulse Rate: ☐ Regular ☐ Irregular

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	6 months from date of exam if ≤140/90	6 months if ≤ 140/90

6. LABORATORY AND OTHER TEST FINDINGS

Numerical readings must be recorded.

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR

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

Other Testing (Describe and record)

7. PHYSICAL EXAMINATION

Height:_____ (in.) Weight:_____ (lbs.) Name: Last, First, Middle,

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, 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 System	Abnormal pulse and amplitude, cartoid or arterial bruits, varicose veins.		
9. Genito-urinary System	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. Insufficicent 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; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinki's reflexes, ataxia.		

***COMMENTS:** _____

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

- ☐ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
- ☐ Does not meet standards
- ☐ Meets standards, but periodic monitoring 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 lense
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____waiver/ exemption. Driver must present exemption at time of certification.
- ☐ 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 _____

Address _____

Telephone Number _____

If meets standards, complete a Medical Examiner's Certificate as stated in 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 ☐ Chiropractor ☐ Physician Assistant ☐ Advanced Practice Nurse

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE

SIGNATURE OF DRIVER	DRIVER'S LICENSE NO.	STATE

ADDRESS OF DRIVER

MEDICAL CERTIFICATE EXPIRATION DATE

HUTCHINSON CLINIC, P.A.

AUTHORIZATION FOR USE, DISCLOSURE OR INSPECTION OF PROTECTED HEALTH INFORMATION AT REQUEST OF THE PATIENT

(Please print all information except for required signature)

Patient Name:_____ Date of Birth: _____

Patient Address: _____

Social Security or other identifier: _____

Type of records/information to be disclosed: _____

Persons, facility, or class of persons who are authorized to use or **disclose** the information:

_____

Persons, facility, or class of persons who are authorized to use or **receive** the records/information:

_____

Purpose for which you want records/information used or disclosed: _____

_____

- I understand that if the person or entity that receives the described records/information is not a health plan covered by federal privacy regulation, the records/information may be redisclosed and no longer protected by those regulations.I may inspect or copy any records/information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation to Hutchinson Clinic, 2101 N Waldron, Hutchinson, KS 67502. If not otherwise revoked this authorization will expire in 90 days after the date of the signature.
- If I revoke this authorization it will have no effect on actions already taken on reliance on this form.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient or am authorized to act on behalf of the patient as the patient's personal representative.
- I understand treatment may not be conditioned upon receipt of this authorization.
- I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the minimum charge for this service is $15.00 for the first 50 pages and $0.35 per page thereafter.

_____ _____

Signature of Patient or Representative Date of Signature

_____

Printed Name of Representative and Relationship to Patient

Phone: 620-669-2500
1-800-779-6979
Fax 620-669-2501