



# Motor Vehicle Division

40-1501 R04/09 www.azdot.gov

## D.O.T. MEDICAL EXAMINATION REPORT

Commercial Driver Fitness Determination

Driver Qualifications at [www.fmcsa.gov](http://www.fmcsa.gov)

### Driver Information – Driver completes this section.

Driver Name (first, middle, last, suffix)		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Driver License Number	Date of Exam
Street Address		City	State	Zip	Home Phone ( )

### Health History – Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Any illness or injury in last 5 years, or any surgery		8. Lung disease, emphysema, asthma, chronic bronchitis		16. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Head/brain injuries, disorders or illness		9. Kidney disease, dialysis		17. Stroke or paralysis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures, epilepsy		10. Liver disease		18. Missing or impaired hand, arm, foot, leg, finger, toe	
Medication:		11. Digestive problems		19. Spinal injury or disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Eye disorders or impaired vision (except corrective lens)		12. Diabetes or elevated blood sugar controlled by:		20. Chronic low back pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diet		21. Regular, frequent alcohol use	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pills		22. Muscular disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Insulin		23. Shortness of breath	
5. Ear disorders, loss of hearing or balance		13. Nervous or psychiatric disorders, e.g., severe depression		24. High blood pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Medication:		Medication:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
6. Heart disease or heart attack; other cardiovascular condition		14. Loss of or altered consciousness		25. Narcotic or habit forming drug	
Medication:		<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	15. Fainting, dizziness			
7. Heart surgery (valve replacement/bypass, angioplasty, pacemaker)					

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) used regularly or recently.

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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 Certificate.

Driver Signature	Date
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**Medical Examiner Comments on Health History** – The medical examiner must review and discuss with driver any Yes answers and potential hazards of medications while driving (including over-the-counter medication). This discussion must be documented below.

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**Vision Section** 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.

**Right Eye:** ☐ Yes ☐ No **Left Eye:** ☐ Yes ☐ No Does this driver have a visual acuity of 20/40 or less?  
**Right Eye:** ☐ Yes ☐ No **Left Eye:** ☐ Yes ☐ No Does this driver require corrective lens to meet the vision standards of 20/40 or less?  
**Right Eye:** ☐ Yes ☐ No **Left Eye:** ☐ Yes ☐ No Does this driver meet the horizontal field of vision standards of 70 degrees or greater?  
☐ Yes ☐ No Driver can recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors?

If vision section completed by an ophthalmologist or optometrist, enter the following:

Date of Exam	Ophthalmologist or Optometrist Name	License Number	State	Signature
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**Hearing Section** Forced whisper test must be completed, or the audiometric test must be completed.

Forced Whisper – **Right Ear:** ☐ Yes ☐ No **Left Ear:** ☐ Yes ☐ No Driver is able to hear a forced whispered voice at 5 feet.

Audiometric – If audiometer is used, record hearing loss in decibels. Loss must be 40 or less at 500, 1000 and 2000Hz (numeric readings only).

Right Ear		
500Hz	1000Hz	2000Hz
Average		

Left Ear		
500Hz	1000Hz	2000Hz
Average		

Driver Name (first, middle, last, suffix)
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Driver License Number
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**Blood Pressure/Pulse Rate** (numerical readings only)

<b>Blood Pressure:</b>	Systolic	Diastolic
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**Pulse Rate:** ☐ Regular ☐ Irregular**Laboratory And Other Test Findings** (numerical readings must be recorded)**Urinalysis is required.** Protein, blood or sugar in urine may be indication for further testing to rule out any underlying medical problem.

Urine Specimen	Sp. Gr.	Protein	Blood	Sugar
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Comments
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**Physical Examination**

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, if 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 compensation has been made for it.

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|--|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. General Appearance                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Abdomen and Viscera  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Eyes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Vascular system  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Ears  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Genito-urinary system  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Mouth and Throat                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Spine, other musculoskeletal  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Heart   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Neurological  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Lungs and chest<br>(not including breast examination) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Extremities– Limb impaired (Driver may be subject to SPE certificate if otherwise qualified.) |

Comments
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**Certification Status** – See [www.fmcsa.dot.gov/rules-regulations/topics/medical/medical.htm](http://www.fmcsa.dot.gov/rules-regulations/topics/medical/medical.htm) for guidance.

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|--|---|
| <input type="checkbox"/> Meets standards in 49 CFR 391.41; qualifies for 2-year certificate  | <input type="checkbox"/> Wearing corrective lenses  |
| <input type="checkbox"/> Does not meet standards   | <input type="checkbox"/> Wearing hearing aid  |
| <input type="checkbox"/> Meets standards, but periodic monitoring required,<br>due to: _____<br>Driver qualified for: <input type="checkbox"/> 3 months <input type="checkbox"/> 1 year <input type="checkbox"/> 6 months<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Accompanied by a _____<br>waiver/exemption. Driver must present exemption<br>at time of certification. |
| <input type="checkbox"/> Temporarily disqualified due to (condition/medication): _____<br>Return to medical examiner's office for follow up on: _____  | <input type="checkbox"/> Skill Performance Evaluation (SPE) Certificate   |
| <input type="checkbox"/> Qualified by operation of 49 CFR 391.64   | <input type="checkbox"/> Driving within an exempt intracity zone<br>(see 49 CFR 391.62)   |

Medical Examiner Name	Title	License/Certificate Number	
Address	City	State	Zip
Medical Examiner Signature	Phone (     )		

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