LABOR RELATIONS

UNITED STATES
POSTAL SERVICE

July 10,.1997

Robert C. Pritchard
Director, Motor Vehicle Services Division
American Postal Workers Union,
AFL-CIO
1300 L Street, NW
Washington, DC 20005-4107

Dear Mr. Pritchard:

This letter responds to your inquiry concerning the use of the appropriate medical form for a Department of Transportation (DOT) physical examination.

Enclosed is a copy of the most current American Trucking Association form which is to be utilized for DOT examinations.

If you have any questions regarding the foregoing, please contact Joyce Ong of my staff at (202) 268-6248.

Sincerely,

Peter A. Sgro
Acting Manager
Contract Administration APWU/NPMHU

Enclosure

475 L'ENFANT PLAZA SW
WASHINGTON DC 20260-4 100

DO NOT RETURN TO ATA

(MEETS DEPARTMENT OF TRANSPORTATION REQUIREMENTS)

Date of Examination _____ New Certification ☐ Recertification ☐

To Be Filled In By Medical Examiner (Please *Print*): Check Here If Not Qualified ☐

Driver's Name _____

Address _____

Soc. Sec. No. _____ Date of Birth _____ Age ____

Health History:

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Nervous stomach	☐	3	Head or spinal injuries
☐	☐	Kidney	☐	☐	Rheumatic fever	☐	☐	Seizures, fits, convulsions, or fainting
☐	☐	Tuberculosis	☐	☐	Muscular disease	☐	☐	Extensive confinement by illness or injury
☐	☐	Syphilis	☐	☐	Psychiatric disorder	3	U	Any other nervous disorder
☐	☐	Gonorrhea	☐	☐	Cardiovascular disease	☐	☐	Suffering from any other disease
☐	☐	Diabetes	☐	☐	Gastrointestinal ulcer	☐	U	Permanent defect from illness, disease or injury

If answer to any of me above is yes, explain _____

General appearance e development: Good _____ Fair _____ Poor _____

Vision: For Distance: Right 20/_____ Left 20/Both _____ 20/ ☐ Without corrective lenses ☐ With corrective lenses, if worn

Evidence of disease or injury . Right _____ Left _____

Color Test _____ Horizontal kid of vision: Right _____ Left _____

Hearing: Right oar _____ Left e a r _____

Disease or injury _____

Audiometric tut: *(If audiometer is used to test hearing)* Decibel loss at: 500 Hz ___ 1,000 Hz ___ 2,000 Hz ___ 4,000 Hz ___ 6,000 Hz ___

Throat:

Thorax: Heart [redacted]

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after exercise _____

Lungs _____

Abdomen: Scars _____ Abnormal masses _____ Tenderness _____

Hernia: Yes _____ No _____ If so, where? _____ Is truss worn? _____

Gastrointestinal: Ulceration or other diseases: Yes _____ No _____

Genito-Urinary: Scars _____ Urethral discharge _____

Reflexes: Rhomberg _____

Pupillary _____ Light: R _____ L _____

Accommodation: Right _____ Left _____

Knee jerks: Right: Normal _____ Increased _____ Absent _____

Left: Normal _____ Increased _____ Absent _____

Remarks: _____

Extremities: Upper _____ Lower _____ Spine _____

Laboratory and Other Special Findings: Urine: Spec. Gr. _____ Alb. _____ Sugar _____

Other Laboratory Data (Serology, etc) _____

Radiological Data _____ Electrocardiograph _____

Controlled Substances Testing: ☐ Controlled substances test performed, ☐ In accordance with Subpart H ☐ Hal in accordance with Subpart H

3 Controlled substances test NOT performed

General Comments: _____

Name of Medical Examiner (Print) _____ Signature _____

Address of Medical Examiner _____

MEDICAL EXAMINER'S CERTIFICATE TO BE COMPLETED ONLY IF DRIVER IS FOUND QUALIFIED

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined

_____

(Driver's name (Print))

In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41 through 391.49) and with knowledge of his/her duties, I find him/her qualified under the regulations. **Expiration date of certificate:** _____

Qualified only when wearing: ☐ Corrective lenses ☐ Hearing aid

☐ Medically unqualified unless accompanied by a _____ waiver

☐ Medically unqualified unless driving within an exempt intracity zone

A completed examination form for this person is on file in my office.

_____ _____ _____

(Area Code/Phone No.) (License/Certificate No.) (State)

_____ _____

(Medical Examiner: (Print Name and Title)) (Signature)

_____

(Signature of Driver)

_____

(Address of Driver)

The following will be completed only when the visual test is conducted by a licensed ophthalmologist or optometrist.

_____

(Date of examination)

_____

(Name of Ophthalmologist or Optometrist (Print))

_____

(Address of Ophthalmologist or Optometrist)

_____

(Signature of Ophthalmologist or Optometrist)

INSTRUCTIONS ON REVERSE SIDE