



**HUMAN PERFORMANCE FACTORS**

**Attachment 3-Commercial Driver Medical Examination Report**

**Oxnard, CA**

**HWY15MH006**

(7 pages)

T-781 P0002/0007 E-070



Motor Vehicle Division

40-1501 R04/14 azdot.gov

D.O.T. MEDICAL EXAMINATION REPORT Commercial Driver Fitness Determination

DRIVER INFORMATION Driver completes this section

Driver Name (first, middle, last, suffix) Jose A. Sanchez Ramirez Date of Birth [redacted] 06 53 Sex [X] Male [ ] Female Date of Exam 8/28/14 Home Telephone [redacted] Street Address [redacted] City [redacted] State [redacted] Zip [redacted] Work Telephone [redacted] Certification [ ] New Certification [X] Re-certification [ ] Follow Up Driver License Number [redacted] License Class [X] A [ ] B [ ] C [ ] D [ ] Other: State of Issue AZ

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

Health history table with columns for Yes/No and categories: Any illness or injury in last 5 years? Head/Brain injuries, disorders or illnesses Seizures, epilepsy Eye disorders or impaired vision (except corrective lenses) Ear disorders, loss of hearing or balance Heart disease or heart attack; other cardiovascular condition Heart surgery (valve replacement/bypass, angioplasty, pacemaker) High blood pressure Muscular disease Shortness of breath Lung disease, emphysema, asthma, chronic bronchitis Kidney disease, dialysis Liver disease Digestive problems Diabetes or elevated blood sugar controlled by: Nervous or psychiatric disorders, e.g., severe depression Loss of, or altered consciousness 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) used regularly or recently.

Medication list box containing handwritten text: losartan 25mg - HTN. Truck Driver

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 [redacted] Date 8/28/14

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

Medical Examiner Comments box containing handwritten text: HTN. losartan.

03-24-'15 10:32 FROM-

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**TESTING** (Medical Examiner must complete the remaining sections.)

DRIVER NAME: Jose A. Sanchez Ramirez

**VISION (Numerical readings must be provided.)** 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 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 vision 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.

Acuity	Uncorrected	Corrected	Horizontal Field Of Vision	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors? Applicant meets visual acuity requirement only when wearing: <input checked="" type="checkbox"/> Corrective Lenses Monocular Vision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Right Eye	20/ 50	20/ 20	Right Eye 90°	
Left Eye	20/ 50	20/ 20	Left Eye 90°	
Both Eyes	20/ 50	20/ 20	180°	

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

Examination Date	Ophthalmologist or Optometrist Name	Phone ( )	License Number	State	Signature
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**HEARING (Numerical readings must be provided.)** 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, -14dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

a) Record distance from individual at which forced whispered voice can first be heard.			b) If audiometer is used, record hearing loss in decibels (acc. to ANSI Z24.5-1951).					
Right Ear	Left Ear		Right Ear			Left Ear		
5 feet	5 feet		500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average			Average			Average		

**BLOOD PRESSURE/PULSE RATE (Numerical readings must be recorded.)** Medical examiner should take at least two readings to confirm BP.

Blood Pressure	Systolic 128	Diastolic 75	Reading	Category	Expiration Date	Recertification
Driver qualified if ≤ 140/90.			140-159/90-99	Stage 1	1 year	1 year if ≤140/90 One-time certificate for 3 months, if 141-159/91-99
Pulse Rate: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular			160-179/100-109	Stage 2	One-time certificate for 3 months	1 year from date of exam if ≤140/90
Record Pulse Rate 85			>180/110	Stage 3	Disqualified 6 months from date of exam if ≤140/90	6 months if ≤140/90

**LABORATORY AND OTHER TEST FINDINGS (Numerical readings must be recorded.)**

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. 1.030	Protein neg	Blood neg	Sugar neg
Other Testing (describe and record)  None -					

03-24-'15 10:32 FROM-

**PHYSICAL EXAMINATION**

Height 5 ft 9 in	Weight 190 lbs	Driver Name Jose A. Sanchez Ramirez	Driver License Number [REDACTED]
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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 abnormalities. Check "No" if body system is normal. Explain any "Yes" answers in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter 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	Body System	Check For
1. General Appearance	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	7. Abdomen and Viscera	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.
2. Eyes	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No 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 specialist if appropriate.	8. Vascular system	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.
3. Ears	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.	9. Genito-urinary system	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Hernias.
4. Mouth and Throat	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Irremediable deformities likely to interfere with breathing or swallowing.	10. Extremities - Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No 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.
5. Heart	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	11. Spine, other musculoskeletal	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Previous surgery, deformities, limitation of motion, tenderness.
6. Lungs and chest, not including breast examination.	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No 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 x-ray of chest.	12. Neurological	<input type="checkbox"/> Yes* <input checked="" type="checkbox"/> No Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.

\*Comments  
None

**MEDICAL EXAMINER CERTIFICATE** (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 evaluation required.

Due to \_\_\_\_\_, driver qualified only for:  
 3 months  1 year **HTN.**  
 6 months  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.  
 Accompanied by Skill Performance Evaluation (SPE) Certificate  
 Driving within an exempt intracity zone. (See 49 CFR 391.62)  
 Qualified by operation of 49 CFR 391.64

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.)

Medical Examiner Name (first, middle, last, suffix) <b>John Smock</b>	Medical License/Certificate Number <b>4570</b>	State <b>AZ</b>	National Registry No. <b>946 121 3823</b>	Phone Number [REDACTED]	Date of Exam <b>8/28/14</b>
Title <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Registered Nurse Practitioner			Medical Examiner Signature 		This Medical Certificate Expires <b>8/28/15</b>
Driver Name (first, middle, last, suffix) <b>Jose A. Sanchez Ramirez</b>		Driver License Number [REDACTED]	State [REDACTED]	Driver Signature [REDACTED]	
Driver Street Address [REDACTED]			State [REDACTED]	Zip [REDACTED]	

40-1504 R04/14

MEDICAL EXAMINER CERTIFICATE

Driver Name  
Jose Alejandro Sanchez Ramirez

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

- Wearing corrective lenses       Wearing a hearing aid
- Accompanied by a \_\_\_\_\_ waiver/exemption
- Driving within an exempt intracity zone
- Qualified by operation of 49 CFR 391.64
- Accompanied by a Skill Performance Evaluation Certificate (SPE)

The information I 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.

Medical Examiner Name (print) <u>John Smock</u>		This Medical Certificate Expires <u>8-28-2015</u>	
Medical Examiner Signature [Redacted]		Date of Exam <u>8/28/2014</u>	
<input type="checkbox"/> Physician's Assistant		National Registry No.	
<input checked="" type="checkbox"/> Chiropractor <input type="checkbox"/> Registered Nurse Practitioner		<u>946 121 3823</u>	
Medical License or Certificate Number <u>4570</u>	State <u>AZ</u>	Phone [Redacted]	
[Redacted]			
Driver License Number [Redacted]		State [Redacted]	
Driver Signature [Redacted]			



SANCHEZ, JOSE ALEJANDRO. - SANJO411 - David Smock - 08/28/2014 5:32 PM

**Subjective**

**Objective**

**Assessment** CDL# [REDACTED] STATE [REDACTED] DOB [REDACTED] IS THIS A CDL  
PHYSICAL YES IS THIS INTRASTATE ONLY N  
RE CERTIFICATION  
TRUCK DRIVER  
MEDS LOSARTAN 25MG

VISION 20/20 ALL CORRECTED/UNCORRECTED 20/50 ALL 90/90/180  
HEARING 5/5  
BP 128/75 PULSE 85  
UA SPGR 1.030 PROTEIN NEG BLOOD NEG SUGAR NEG  
HEIGHT 5'9 WEIGHT 190

**PHYSICAL FINDINGS**

RESULT PASS EXP DATE 8/28/2015

GLASSES Y HEARING AID N

**Plan**

**Medications**

**Follow Up**

MEDICAL EXAMINER'S CERTIFICATE				
I certify that I have examined <u>JOSE ALEJANDRO SANCHEZ RAMIREZ</u> 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:				
<input checked="" type="checkbox"/> wearing corrective lenses <input type="checkbox"/> wearing hearing aid <input type="checkbox"/> accompanied by a _____ waiver/exemption		<input type="checkbox"/> driving within an exempt intracity zone (49 CFR 391.62) <input type="checkbox"/> accompanied by a Skill Performance Evaluation Certificate (SPE) <input type="checkbox"/> 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
		[REDACTED]		08/28/2014
MEDICAL EXAMINER'S NAME (PRINT)		<input type="checkbox"/> MD <input type="checkbox"/> DO <input checked="" type="checkbox"/> Physician Assistant <input type="checkbox"/> Chiropractor <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> Other Practitioner		
John P Smock				
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE		NATIONAL REGISTRY NO.		
4570 / AZ		9461213823		
SIGNATURE OF DRIVER		INTRASTATE ONLY	CDL	DRIVER'S LICENSE NO.
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	[REDACTED]
ADDRESS OF DRIVER		STATE		
		[REDACTED]		
MEDICAL CERTIFICATION EXPIRATION DATE				
08/28/2015				