Motor Carrier Attachment 18:

Accident Driver's DOT Medical Examination Report

Oxnard, California

HWY15MH006

(7 pages)

ADOT
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)	Date of Birth	Age	Sex	Date of Exam	Home Telephone
[redacted]	[redacted]	[redacted]	☒ Male ☐ Female	8/28/14	[redacted]
Street Address: [redacted]	City: Yuma		State: AZ	Zip: 85364	
Certification: ☐ New Certification ☒ Re-certification ☐ Follow Up	Driver License Number: [redacted]	License Class: ☒ A ☐ B ☐ C ☐ D ☐ Other:		State of Issue: AZ	

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

Yes	No		Yes	No		Yes	No	
☐	☒	Any illness or injury in last 5 years?	☐	☒	Lung disease, emphysema, asthma, chronic bronchitis	☐	☒	Fainting, dizziness
☐	☒	Head/Brain injuries, disorders or illnesses	☐	☒	Kidney disease, dialysis	☐	☒	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☒	Seizures, epilepsy ☐ Medication:	☐	☒	Liver disease	☐	☒	Stroke or paralysis
☐	☒	Eye disorders or impaired vision (except corrective lenses)	☐	☒	Digestive problems	☐	☒	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☒	Ear disorders, loss of hearing or balance	☐	☒	Diabetes or elevated blood sugar controlled by: ☐ Diet ☐ Pills ☐ Insulin	☐	☒	Spinal injury or disease
☐	☒	Heart disease or heart attack; other cardiovascular condition ☐ Medication:	☐	☒	Nervous or psychiatric disorders, e.g., severe depression ☐ Medication:	☐	☒	Chronic low back pain
☐	☒	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	☐	☒	Loss of, or altered consciousness	☐	☒	Regular, frequent alcohol use
☒	☐	High blood pressure ☐ Medication:				☐	☒	Narcotic or habit forming drug use
☐	☒	Muscular disease						
☐	☒	Shortness of breath						

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.

losartan 25 mg - 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	Date
[redacted]	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.)

HTN. losartan.

T-781 P0003/0007 F-070

TESTING (Medical Examiner must complete the remaining sections.)

Driver Name [redacted]

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
Right Eye	20/ 50	20/ 20
Left Eye	20/ 50	20/ 20
Both Eyes	20/ 50	20/ 20

Horizontal Field Of Vision	
Right Eye	90 °
Left Eye	90 °
	180°

☑ Yes ☐ 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: ☑ Corrective Lenses

Monocular Vision? ☐ Yes ☑ No

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
		( )			

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.

Right Ear	Left Ear
5 feet	5 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		

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

Blood Pressure	Systolic	Diastolic	Reading	Category	Expiration Date	Recertification
Driver qualified if ≤ 140/90.	128	75	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: ☑ Regular ☐ 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.	Protein	Blood	Sugar
		1.030	neg	neg	neg

Other Testing (describe and record)

None -

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T-781 P0004/0007 F-070

PHYSICAL EXAMINATION

Height	Weight	Driver Name	Driver License Number
5 ft 9 in	190 lbs	[redacted]	[redacted]

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	☐ Yes* ☒ No	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	7. Abdomen and Viscera	☐ Yes* ☒ No	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.
2. Eyes	☐ Yes* ☒ 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	☐ Yes* ☒ No	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.
3. Ears	☐ Yes* ☒ No	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.	9. Genito-urinary system	☐ Yes* ☒ No	Hernias.
4. Mouth and Throat	☐ Yes* ☒ No	Irremediable deformities likely to interfere with breathing or swallowing.	10. Extremities – Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	☐ Yes* ☒ 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	☐ Yes* ☒ No	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	11. Spine, other musculoskeletal	☐ Yes* ☒ No	Previous surgery, deformities, limitation of motion, tenderness.
6. Lungs and chest, not including breast examination.	☐ Yes* ☒ 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	☐ Yes* ☒ 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 HTN., driver qualified only for:
  - ☐ 3 months ☒ 1 year ☐ 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)	Medical License/Certificate Number	State	National Registry No.	Phone Number	Date of Exam
[redacted]	[redacted]	AZ	[redacted]	[redacted]	8/28/14

Title	Medical Examiner Signature	This Medical Certificate Expires
☐ MD ☐ DO ☐ Chiropractor ☐ Physician's Assistant ☐ Registered Nurse Practitioner	[redacted]	8/28/15

Driver Name (first, middle, last, suffix)	Driver License Number	State	Driver Signature
[redacted]	[redacted]	AZ	[redacted]

Driver Street Address	City	State	Zip
[redacted]	Yuma	AZ	85364

03-24-'15 10:33 FROM-

40-1504 R04/14

MEDICAL EXAMINER CERTIFICATE

Driver Name
[redacted]

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) [redacted]	This Medical Certificate Expires [redacted]
Medical Examiner Signature [redacted]	Date of Exam 8/28/2014
☐ MD ☐ DO ☒ Physician's Assistant ☐ Chiropractor ☐ Registered Nurse Practitioner	National Registry No. [redacted]
Medical License or Certificate Number [redacted]	State AZ Phone [redacted]
Driver Address, City, State, Zip [redacted]	AZ 85364
Driver License Number [redacted]	State AZ
Driver Signature [redacted]	

[redacted] - SANJO411 - [redacted] 08/28/2014 5:32 PM

Subjective

Objective

Assessment CDL# [redacted] STATE AZ 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 [redacted]

GLASSES Y HEARING AID N

Plan

Medications

Follow Up

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined [redacted] 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
	[redacted]	08/28/2014

MEDICAL EXAMINER'S NAME (PRINT)		
[redacted]	☐ MD ☐ DO ☑ Physician Assistant	☐ Chiropractor ☐ Advanced Practice Nurse ☐ Other Practitioner

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE	NATIONAL REGISTRY NO.
[redacted] AZ	[redacted]

SIGNATURE OF DRIVER	INTRASTATE ONLY	CDL	DRIVER'S LICENSE NO.	STATE
	☐ YES ☑ NO	☑ YES ☐ NO	[redacted]	AZ

ADDRESS OF DRIVER

MEDICAL CERTIFICATION EXPIRATION DATE

08/28/2015