

Human Performance Group Chairman's Factual Report

**Gray Summit, Missouri
HWY-10-MH-018**

Attachment 4: 2007 Volvo Driver Commercial Driver Fitness Determination

(5 pages)

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) Crabtree, Michael D		Social Security No. [REDACTED]	Birthdate [REDACTED] M/D/Y	Age 42	Sex [X] M [] F	[X] New certification [] Recertification [] Follow Up	Date of Exam 07/13/2009
Address [REDACTED]	City, State, Zip Code [REDACTED]	Work Tel: (888) 305-0450 Home Tel: [REDACTED]		Driver License No. [REDACTED]	License Class [X] A [] C [] B [] D [] Other		State of Issue WV
2. HEALTH HISTORY		Driver completes this section, but medical examiner is encouraged to discuss with driver.					
YES NO <input checked="" type="checkbox"/> Any illness or injury in the last 5 years? <input type="checkbox"/> <input checked="" type="checkbox"/> Head/Brain injuries, disorders or illnesses <input type="checkbox"/> <input checked="" type="checkbox"/> Seizures, epilepsy <input type="checkbox"/> medication _____ <input type="checkbox"/> <input checked="" type="checkbox"/> Eye disorders or impaired vision (except corrective lenses) <input type="checkbox"/> <input checked="" type="checkbox"/> Ear disorders, loss of hearing or balance <input type="checkbox"/> <input checked="" type="checkbox"/> Heart disease or heart attack; other cardiovascular condition <input type="checkbox"/> medication _____ <input type="checkbox"/> <input checked="" type="checkbox"/> Heart surgery (valve replacement/bypass,angioplasty,pacemaker) <input type="checkbox"/> <input checked="" type="checkbox"/> High blood pressure [] medication _____ <input type="checkbox"/> <input checked="" type="checkbox"/> Muscular disease <input type="checkbox"/> <input checked="" type="checkbox"/> Shortness of breath		YES NO <input type="checkbox"/> <input checked="" type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis <input type="checkbox"/> <input checked="" type="checkbox"/> Kidney disease, dialysis <input type="checkbox"/> <input checked="" type="checkbox"/> Liver disease <input type="checkbox"/> <input checked="" type="checkbox"/> Digestive problems <input type="checkbox"/> <input checked="" type="checkbox"/> Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> diet <input type="checkbox"/> pills <input type="checkbox"/> insulin <input type="checkbox"/> <input checked="" type="checkbox"/> Nervous or psychiatric disorders, e.g., severe depression <input type="checkbox"/> medication _____ <input type="checkbox"/> <input checked="" type="checkbox"/> Loss of, or altered consciousness		YES NO <input type="checkbox"/> <input checked="" type="checkbox"/> Fainting, dizziness <input type="checkbox"/> <input checked="" type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring <input type="checkbox"/> <input checked="" type="checkbox"/> Stroke or paralysis <input type="checkbox"/> <input checked="" type="checkbox"/> Missing or impaired hand, arm, foot, leg, finger, toe <input type="checkbox"/> <input checked="" type="checkbox"/> Spinal injury or disease <input type="checkbox"/> <input checked="" type="checkbox"/> Chronic low back pain <input type="checkbox"/> <input checked="" type="checkbox"/> Regular, frequent alcohol use <input type="checkbox"/> <input checked="" type="checkbox"/> 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

07/13/2009

 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)

No Current Health Problem



TESTING (Medical Examiner completes Section 3 through 7) Name: Crabtree, Michael D

3. VISION 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'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/ <u>20</u>	20/	Right Eye <u>130°</u>
Left Eye	20/ <u>20</u>	20/	Left Eye <u>130°</u>
Both Eyes	20/ <u>15</u>	20/	<u>180°</u>

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 ophthalmologist 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 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.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear <u>29</u> Feet	Left Ear <u>29</u> 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 <u>136</u>	Diastolic <u>90</u>
Not qualified if ≤ 140/90.		
Pulse Rate:	<input checked="" type="checkbox"/> Regular [] Irregular	
Record Pulse Rate:	<u>80</u>	

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.

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

	SP. GR.	PROTEIN	BLOOD	SUGAR
URINE SPECIMEN	<u>1.010</u>	<u>Neg</u>	<u>Neg</u>	<u>Neg</u>

Other Testing (Describe and record)

7. PHYSICAL EXAMINATION

Height: 5'10" (in.) Weight: 220 (lbs.)

Name: Crabtree, Michael D

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 amendable 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	BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.		<input checked="" type="checkbox"/>	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia significant abdominal wall muscle weakness.		<input checked="" type="checkbox"/>
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.		<input checked="" type="checkbox"/>	8. Vascular system	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		<input checked="" type="checkbox"/>
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.		<input checked="" type="checkbox"/>	9. Genito- urinary system	Hernias.		<input checked="" type="checkbox"/>
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.		<input checked="" type="checkbox"/>	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. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.		<input checked="" type="checkbox"/>
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.		<input checked="" type="checkbox"/>	11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		<input checked="" type="checkbox"/>
6. Lungs and chest, not including breast examination.	Abnormal chest wall examination, 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.		<input checked="" type="checkbox"/>	12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		<input checked="" type="checkbox"/>

*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

- Wearing corrective lenses
- 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

Temporarily disqualified due to (condition or medication): _____

Return to medical examiner's office for follow up on _____

Medical Examiner's Signature [Signature]
 Medical Examiner's Name Charles E Keefe, MD Corp Health
 Address 1701 Heritage Hills Drive Washington, MO 63090
 Telephone Number (636) 239-8844

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

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined Michael Crabtree 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 _____ w/silver/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 <i>[Signature]</i>	Telephone 636-239-8844	Date 7-13-09
Medical Examiner's Name (print) Charles Keefe	<input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Chiropractor <input type="checkbox"/> Advanced Practice Nurse
Medical Examiner's License or Certificate No. / Issuing State [Redacted] / [Redacted]		
Signature of Driver <i>[Signature]</i>	Driver's License No. [Redacted]	ST WV
Address of Driver [Redacted]		
Medical Certificate Expiration Date 07/13/2011		