DOT Medical Card Clearance

Date:_____

Patient Information

Name: _____ DOB:_____

Condition(s) for which you are treating patient:

_____
_____
_____
_____

Medications:

_____
_____
_____

Treating Physician Findings

I have reviewed the FMCSA (Federal Motor Carrier Safety Administration) recommendations regarding certification of drivers with these medical conditions and taking these medications.

FMCSA website: http://nrcme.fmcsa.dot.gov/documents/FMCSAMedicalExaminerHandbook-2014MAR18.pdf (page 18-20 of Medical Examiner Handbook).

I have also reviewed the attached job description for a DOT driver.
Below is my opinion on the patient's ability to perform duties as an over the road tractor trailer (semi-truck) driver:

_____YES _____NO

Comments

_____
_____

Treating Physician Information

Name:_____

Address:_____

Phone: _____ Fax:_____

Signature:_____

We welcome any questions you may have regarding the FMCSA CDL medical certification process.

Please fax the completed form to 406.488.5499