Employer Name: _____

Medical Examination Report

Non-DOT Fitness Determination

Clinic: _____

1. APPLICANT INFORMATION

Reason For Test:

Applicant's Name (Last, First, Middle)	Social Security Number	Birthdate	Age	Gender	Date of Exam

Address	City, ST, Zip	Phone	Driver's License #	License Class	State of Issue
		Work: Home:		☐ A ☐ C ☐ B ☐ D ☐ Other	

2. Health History Applicant completes this section, but medical examiner is encouraged to discuss with patient.

		Yes	No			Yes	No
1	Any illness or injury in the last 5 years?	☐	☐	13	Liver disease	☐	☐
2	Head/Brain injuries, disorders or illnesses?	☐	☐	14	Digestive problems	☐	☐
3	Seizures, epilepsy	☐	☐	15	Diabetes or elevated blood sugar controlled by	☐	☐
	Medication ☐ _____				Diet ☐ Pills ☐ Insulin ☐		
4	Eye Disorders or impaired vision (except corrective lenses)	☐	☐	16	Nervous or psychiatric disorders, e.g., severe depression	☐	☐
5	Ear disorders, loss of hearing or balance	☐	☐		Medication ☐ _____		
6	Heart disease or heart attack; other cardiovascular condition	☐	☐	17	Loss of, or altered consciousness	☐	☐
	Medication ☐ _____			18	Fainting, dizziness	☐	☐
7	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	☐	☐	19	Sleep disorders, sleep apnea, loud snoring	☐	☐
8	High Blood Pressure	☐	☐	20	Stroke or paralysis	☐	☐
	Medication ☐ _____			21	Missing or impaired hand, arm, foot, leg, finger, toe	☐	☐
9	Muscular disease	☐	☐	22	Spinal injury or disease	☐	☐
10	Shortness of breath	☐	☐	23	Chronic low back pain	☐	☐
11	Lung disease, emphysema, asthma, chronic bronchitis	☐	☐	24	Regular, frequent alcohol use	☐	☐
12	Kidney disease, dialysis	☐	☐	25	Narcotic or habit forming drug use	☐	☐

For any YES answer, indicate onset date, diagnosis, treating physician's name, 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.

_____ _____

Applicant's Signature Date

Medical Examiner Comments

TESTING (Medical Examiner completes Section 3 through 8)

Employer Name: _____ Applicant Name: _____

3. VISION

The use of corrective lenses should be noted.

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 feed as a denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If applicant habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye	20 /	20 /	Right Eye:
Left Eye	20 /	20 /	Left Eye:
Both Eyes	20 /	20 /	

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

4. HEARING

☐ Check if hearing aid used for tests.

Instructions: To convert automatic test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be provided. Complete either Section A or B

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear	Left Ear
	feet	feet

b) If audiometer is used, record hearing loss in decibels. (acc. To ANSI Z24.5-1951)

Right Ear			Left Ear		
50 Hz	1000 Hz	2000 Hz	50 Hz	1000 Hz	2000 Hz
Average:			Average:		

5. BLOOD PRESSURE / PULSE RATE **Numerical readings must be recorded.**

Blood Pressure	Systolic	Diastolic

Pulse Rate: ☐ Regular ☐ Irregular
Record Pulse Rate:

6. LABORATORY & OTHER 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.Grav.	Protein	Blood	Sugar

Other testing (Describe and record):

Employer Name: _____ Applicant Name: _____

7. PHYSICAL EXAMINATION

Height: _____ Weight: _____ BMI: _____

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.

BODY SYSTEM	CHECK FOR:	YES	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	☐	☐
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.	☐	☐
3. Ears	Middle ear disease, occlusion of external canal, perforated eardrums.	☐	☐
4. Mouth & Throat	Irremediable deformities likely to interfere with breathing or swallowing.	☐	☐
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	☐	☐
6. Lungs and Chest	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezing or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may lead to pulmonary tests or a chest x-ray.	☐	☐
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hemia, significant abdominal wall muscle weakness.	☐	☐
8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, vericose veins.	☐	☐
9. Genito-urinary System	Hernias	☐	☐
10. Extremities	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp & prehension in upper limb to maintain steering wheel grip. Insufficient mobility & strength in lower limb to operate pedals properly.	☐	☐
11. Spine, Musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.	☐	☐
12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar & Babinski's reflexes, ataxia.	☐	☐

Examiner Comments:

8. Final Disposition & Certification

PASS ☐ I have examined the individual named above and to the best of my knowledge, he/she is in good physical and mental health and is able to function in his/her profession in full capacity.

FAIL ☐ I have examined the individual named above and to the best of my knowledge, he/she is not in good physical and/or mental health and is not able to function in his/her profession in full capacity.

Medical Examiner's Signature: _____

Medical Examiner's Name (print): _____

Address: ALTMED MEDICAL CENTER, 8714 SUDLEY ROAD, MANASSAS,VA 20110

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