Altmed Medical Center
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Return to Duty / Work DOT Clearance Form

Please use this form to provide additional information related to the medical condition defined below. This information is necessary for our assessment of a driver's ability to safely operate a commercial motor vehicle.

Patient Information: (Please Print)

Last Name: ____________ First: ____________ Middle: ____________

Date of Birth: / / Date of Exam: / /

Supplemental Medical Information:

The above patient has presented for their DOT medical examination noting a history of ____________

Please provide the following information so the medical examiner may complete the DOT medical examination. By signing below, you are only attesting to the patient's defined medical condition.

Diagnosis: ____________

Procedure(s) Performed: ____________ Date: / /

____________ Date: / /

____________ Date: / /

Medication (Including Dosage): ____________

Patient may return to work without restrictions? Check one: ☐ YES ☐ NO

Date patient may return to work without restrictions: / /

The patient has the following restrictions: ____________

Follow-up Date: / /

Treating Medical Provider Recommendation

Treating Medical Provider:

Given your knowledge of the patient's medical condition, do you feel they can safely operate a commercial motor vehicle? Check one: ☐ YES ☐ NO

Provider: ____________ Signature: ____________ Date: / /

Thank you for providing the requested information. Please email or fax the completed form to our office.

FOR ALTMED MEDICAL CENTER STAFF USE ONLY:

Medical Examiner: ____________ Signature: ____________ Date: / /