MCSA-5870

OMB No.: 2126-0006
Expiration Date: 03/31/2028

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

Individual's Name: _____

INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

Name: _____ **DOB:** _____

Driver's License Number *(if applicable)*: _____ **State:** _____

This individual is being evaluated either to determine whether he/she meets the physical qualification standards of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle or because the individual has recently experienced a severe hypoglycemic episode. A treating clinician should complete this form to the best of his/her ability based on his/her knowledge of the individual's medical history. Completion of this form does not imply that a treating clinician is making a medical certification decision to qualify the individual to drive a commercial motor vehicle. Any determination as to whether the individual is physically qualified to drive a commercial motor vehicle will be made by a certified medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines a treating clinician as a healthcare professional who manages, and prescribes insulin for, treatment of the individual's diabetes mellitus as authorized by the healthcare professional's applicable State licensing authority.

Instructions to the Individual:

When you are being evaluated prior to a medical certification examination, the certified medical examiner must receive this form and begin the examination no later than 45 calendar days after a treating clinician signs this form.

When you are being evaluated after a severe hypoglycemic episode, you must retain this form and give it to the certified medical examiner at your next medical certification examination.

Insulin-Treated Diabetes Mellitus Diagnosis

1. Date insulin use began: _____

Blood Glucose Self-Monitoring Records

2. Has the individual maintained at least the preceding 3 months of ongoing blood glucose self-monitoring records while being treated with insulin that are measured with an electronic glucometer that stores all readings, records the date and time of readings, and from which data can be electronically downloaded?

   ☐ Yes ☐ No

3. Has the individual provided at least the preceding 3 months of electronic self-monitoring records while being treated with insulin from his/her glucometer to the treating clinician for review?

   ☐ Yes ☐ No

If no, provide details:

_____

Note: *The individual is not physically qualified to operate a commercial motor vehicle for up to the maximum 12-month period until he/she provides a treating clinician with at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with insulin. At the certified medical examiner's discretion, the individual who does not possess at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with insulin may qualify to operate a commercial motor vehicle for up to but not more than 3 months.*

4. How many times per day is the individual testing his/her blood glucose? _____

5. Is the individual compliant with blood glucose self-monitoring based on his/her specific treatment plan?

☐ Yes ☐ No

Comments, if necessary:

_____

Severe Hypoglycemic Episodes

6. Has the individual experienced any severe hypoglycemic episodes within the preceding 3 months? *FMCSA defines a severe hypoglycemic episode as one that requires the assistance of others, or results in loss of consciousness, seizure, or coma.*

☐ Yes ☐ No

If yes, provide date(s) of occurrence, whether the cause has been addressed, and associated details (attach additional pages as needed):

_____ ATTACH FILE

_____

Hemoglobin A1C (HbA1C) Measurements

7. Has the individual had HbA1C measured intermittently over the last 12 months, with the most recent measure within the preceding 3 months?

☐ Yes ☐ No

If yes, attach the most recent result. ATTACH FILE

Diabetes Complications

8. Does the individual have signs of diabetic complications or target organ damage? *This information will be used by the certified medical examiner in determining whether the listed conditions would impair the individual's ability to safely operate a commercial motor vehicle.*

   a. Renal disease/renal insufficiency (e.g., diabetic nephropathy, proteinuria, nephrotic syndrome)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

b. Diabetic cardiovascular disease (e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

c. Neurological disease/autonomic neuropathy (e.g., cardiovascular, gastrointestinal, genitourinary)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

d. Peripheral neuropathy (e.g., sensory loss, decreased sensation, loss of vibratory sense, loss of position sense)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, location, type of involvement, current treatment, and whether the condition is stable:

_____

_____

e. Lower limb (e.g., foot ulcers, amputated toes/foot, infection, gangrene)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

f. Other? *(specify condition)*: _____

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

Progressive Eye Diseases

9. Date of last comprehensive eye examination: _____

10. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?

☐ Yes ☐ No

If yes, provide date of diagnosis: _____

Individual's Name: _____

11. Has the individual been diagnosed with any other progressive eye disease(s) (e.g., macular edema, cataracts, glaucoma)?

☐ Yes ☐ No

If yes, specify the disease(s), provide the dates of diagnoses, current treatment, and whether the condition is stable:

_____

_____

12. Additional Comments *(attach additional pages as needed)*

_____

_____

_____

_____

ATTACH FILE

I attest that I am a treating clinician (as defined above), that this individual maintains a stable insulin regimen and proper control of his/her insulin-treated diabetes mellitus, and that the information provided is true and correct to the best of my knowledge.

_____
Date

_____ _____
Printed Name and Medical Credential *Signature*

_____
Professional License Number and State

_____ _____
Phone Number *Email*

_____ _____
Street Address *City, State, Zip Code*

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

_____

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ◯ Yes ◯ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ◯ Yes ◯ No ◯ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ **Yes** ○ **No** ○ **Not Sure**

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ **Yes** ○ **No** ○ **Not Sure**

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: ○ Yes ○ No Height: ___ *feet* ___ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading *(optional)*		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

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

Other testing if indicated

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

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

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

*Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	_____	_____

OR

Audiometric Test Results

Right Ear:			Left Ear:		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
_____	_____	_____	_____	_____	_____

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

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 neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	**Body System**	Normal	Abnormal
1. General	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Genito-urinary system including hernias	○	○
3. Eyes	○	○	10. Back/spine	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Neurological system including reflexes	○	○
6. Cardiovascular	○	○	13. Gait	○	○
7. Lungs/chest	○	○	14. Vascular system	○	○

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

○ Does not meet standards *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*

○ Determination pending *(specify reason)*: _____

☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____

☐ Medical Examination Report amended *(specify reason)*: _____

(if amended) Medical Examiner's Signature: _____ Date: _____

○ Incomplete examination *(specify reason)*: _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):

○ Does not meet standards in 49 CFR 391.41 with any applicable State variances *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41 with any applicable State variances

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements *(State)*

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

Instructions for Completing the Medical Examination Report Form (MCSA-5875)

I. Step-By-Step Instructions

Driver:

Section 1: Driver Information

- **Personal Information:** Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, driver's license number and issuing state.
    - **CLP/CDL Applicant/Holder:** Check "yes" if you are a commercial learner's permit (**CLP**) or commercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
    - **Driver ID Verified By:** The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
    - **Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box "yes" or "no" and if you aren't sure check the "not sure" box.
- **Driver Health History:**
    - **Have you ever had surgery:** Please check "yes" if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
    - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check "yes" if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
    - **#1-32:** Please complete this section by checking the "yes" box to indicate that you have, or have ever had, the health condition listed or the "No" box if you have not. Check the "not sure" box if you are unsure.
    - **Other Health Conditions not described above:** If you have, or have had, any other health conditions not listed in the section above, check "Yes" and in the box provided and list those condition(s).
    - **Any yes answers to questions #1-32 above:** If you have answered "yes" to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered "yes" to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked "yes" to question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

Medical Examiner:

Section 2: Examination Report

- **Driver Health History Review:** Review answers provided by the driver in the driver health history section and discuss any "yes" and "not sure" responses. In addition, be sure to compare the medication list to the health history responses ensuring that the medication list matches the medical conditions noted. Explore with the driver any answers that seem unclear. Record any information that the driver omitted. As the Medical Examiner conducting the driver's physical examination you are required to complete the entire medical examination even if you detect a medical condition that you consider disqualifying, such as deafness. Medical Examiners are expected to determine the driver's physical qualification for operating a commercial vehicle safely. Thus, if you find a disqualifying condition for which a driver may receive a Federal Motor Carrier Safety Administration medical exemption, please record that on the driver's Medical Examiner's Certificate, Form MCSA-5876, as well as on the Medical Examination Report Form, MCSA-5875.
- **Testing:**
  - **Pulse rate and rhythm, height, and weight:** record these as indicated on the form.
  - **Blood Pressure:** record the blood pressure (systolic and diastolic) of the driver being examined. A second reading is optional and should be recorded if found to be necessary.
  - **Urinalysis:** record the numerical readings for the specific gravity, protein, blood and sugar.
  - **Vision:** The current vision standard is provided on the form. When other than the Snellen chart is used, give test results in Snellen-comparable values. When recording distance vision, use 20 feet as normal. Record the vision acuity results and indicate if the driver can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors; has monocular vision; has been referred to an ophthalmologist or optometrist; and if documentation has been received from an ophthalmologist or optometrist.
  - **Hearing:** The current hearing standard is provided on the form. Hearing can be tested using either a whisper test or audiometric test. Record the test results in the corresponding section for the test used.
- **Physical Examination:** Check the body systems for abnormalities and indicate normal or abnormal for each body system listed. Discuss any abnormal answers in detail in the space provided and indicate whether it would affect the driver's ability to safely operate a commercial motor vehicle.

In this next section, you will be completing either the Federal or State determination, not both.

- **Medical Examiner Determination (Federal):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49). Complete the medical examiner determination section completely. When determining a driver's physical qualification, please note that English language proficiency (49 CFR part 391.11: General qualifications of drivers) is not factored into that determination.
  - **Does not meet standards:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41.
  - **Meets standards in 49 CFR 391.41; qualifies for 2-year certification:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting "other" specify the time frame.
  - **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, driving within an exempt intracity zone, etc.).
- **Determination pending:** Select this option when more information is needed to make a qualification decision and specify a date, on or before the 45 day expiration date, for the driver to return to the medical exam office for follow-up. This will allow for a delay of the qualification decision for as many as 45 days. If the disposition of the pending examination is not updated via the National Registry on or before the 45 day expiration date, FMCSA will notify the examining medical examiner and the driver in writing that the examination is no longer valid and that the driver is required to be re-examined.
  - **MER amended:** A Medical Examination Report Form (MER), MCSA-5875, may only be amended while in determination pending status for situations where new information (e.g., test results, etc.) has been received or there has been a change in the driver's medical status since the initial examination, but prior to a final qualification determination. Select this option when a Medical Examination Report Form, MCSA-5875, is being amended; provide the reason for the amendment, sign and date. In addition, initial and date any changes made on the Medical Examination Report Form, MCSA-5875. A Medical Examination Report Form, MCSA-5875, cannot be amended after an examination has been in determination pending status for more than 45 days or after a final qualification determination has been made. The driver is required to obtain a new physical examination and a new Medical Examination Report Form, MCSA-5875, should be completed.
- **Incomplete examination:** Select this when the physical examination is not completed for any reason (e.g., driver decides they do not want to continue with the examination and leaves) other than situations outlined under determination pending.
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

- **Medical Examiner Determination (State):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations). Complete the medical examiner determination section completely.
  - **Does not meet standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41 with any applicable State variances.
  - **Meets standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting "other" specify the time frame.
  - **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, etc.).
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

II. If updating an existing exam, you must resubmit the new exam results, via the Medical Examination Results Form, MCSA-5850, to the National Registry, and the most recent dated exam will take precedence.

III. To obtain additional information regarding this form go to the Medical Program's page on the Federal Motor Carrier Safety Administration's website at http://www.fmcsa.dot.gov/regulations/medical.

Please note, the expiration date on this form relates to the process for renewing the Information Collection Request that includes this form with the Office of Management and Budget. This requirement to collect information as requested on this form does not expire.

391.41 CMV DRIVER MEDICATION FORM

Responsibilities, work schedules, physical and emotional demands, and lifestyles among commercial drivers vary by the type of driving that they do. Some of the main types of drivers include the following: turn around or short relay (drivers return to their home base each evening); long relay (drivers drive 9-11 hours and then have at least a 10-hour off-duty period), straight through haul (cross country drivers); and team drivers (drivers share the driving by alternating their 5-hour driving periods and 5-hour rest periods.) The following factors may be involved in a driver's performance of duties: abrupt schedule changes and rotating work schedules, which may result in irregular sleep patterns and a driver beginning a trip in a fatigued condition; long hours; extended time away from family and friends, which may result in lack of social support; tight pickup and delivery schedules, with irregularity in work, rest, and eating patterns, adverse road, weather and traffic conditions, which may cause delays and lead to hurriedly loading or unloading cargo in order to compensate for the lost time; and environmental conditions such as excessive vibration, noise, and extremes in temperature. Transporting passengers or hazardous materials may add to the demands on the commercial driver. There may be duties in addition to the driving task for which a driver is responsible and needs to be fit. Some of these responsibilities are: coupling and uncoupling trailer(s) from the tractor, loading and unloading trailer(s) (sometimes a driver may lift a heavy load or unload as much as 50,000 lbs. of freight after sitting for a long period of time without any stretching period); inspecting the operating condition of tractor and/or trailer(s) before, during and after delivery of cargo; lifting, installing, and removing heavy tire chains; and, lifting heavy tarpaulins to cover open top trailers. The above tasks demand agility, the ability to bend and stoop, the ability to maintain a crouching position to inspect the underside of the vehicle, frequent entering and exiting of the cab, and the ability to climb ladders on the tractor and/or trailer(s). In addition, a driver must have the perceptual skills to monitor a sometimes complex driving situation, the judgment skills to make quick decisions, when necessary, and the manipulative skills to control an oversize steering wheel, shift gears using a manual transmission, and maneuver a vehicle in crowded areas.

CERTIFIED MEDICAL EXAMINER'S REQUEST FOR INFORMATION

Driver Name: _____ **Date of Birth:** _____

The above patient/driver is being evaluated to determine whether he/she meets the medical standards of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle (CMV) in interstate commerce. During the medical evaluation, it was determined this individual is taking medication(s) that may impair his/her ability to safely operate a CMV. As the certified Medical Examiner (ME), I request that you review the regulations as noted below, complete this form, and return it to me at the mailing address, email address, or fax number specified below. The final determination as to whether the individual listed in this form is physically qualified to drive a CMV will be made by the certified ME.

49 CFR 391.41(b), **Physical Qualifications for Drivers: A person is physically qualified to drive a CMV if that person … (12)(i) Does not use any drug or substance identified in 21 CFR 1308.11 Schedule I, an amphetamine, a narcotic, or other habit-forming drug. (ii) Does not use any non-Schedule I drug or substance that is identified in the other Schedules in 21 part 1308 except when the use is prescribed by a licensed medical practitioner, as defined in § 382.107, who is familiar with the driver's medical history and has advised the driver that the substance will not adversely affect the driver's ability to safely operate a CMV.**

Printed Name of Certified Medical Examiner: _____ Date: _____

Street Address: _____ City, State, Zip Code: _____

Email Address: _____ Fax Number: _____

Signature of Certified Medical Examiner: _____

Use of this form by the certified medical examiner is voluntary.

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

PRESCRIBING HEALTHCARE PROVIDER DATA

1. List all medications and dosages that you have prescribed to the above named individual.

2. List any other medications and dosages that you are aware have been prescribed to the above named individual by another treating health care provider.

3. What medical conditions are being treated with these medications?

4. It is my medical opinion that, considering the mental and physical requirements of operating a CMV and with awareness of a CMV driver's role (consistent with "The Driver's Role" statement on page 1), my patient:

(a) has no medication side effects from medication(s) that I prescribe that would adversely affect the ability to safely operate a CMV; and

(b) has no medical condition(s) that I am treating with the above medication(s) that would adversely affect the ability to safely operate a CMV.

○ Yes ○ No

Printed Name of Prescribing Healthcare Provider: _____ State of Licensure: _____

Street Address: _____ City, State, Zip Code: _____

Email Address: _____ Fax Number: _____ Date: _____

Signature of Prescribing Healthcare Provider: _____

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U.S. Department of Transportation
Federal Motor Carrier Safety Administration

NON-INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

Driver Name: _____ **DOB:** _____

The individual named above is being evaluated to determine whether the individual meets the physical qualification standards of the Federal Motor Carrier Safety Administration to operate a commercial motor vehicle in interstate commerce. During the medical evaluation, it was determined this individual has a diagnosis of non-insulin-treated diabetes mellitus. Although there is not a standard specific to non-insulin-treated diabetes mellitus, this information will be used by the certifying medical examiner to evaluate any diabetes-related complications and/or target organ damage and to determine whether the individual's physical condition is adequate to enable the individual to operate a commercial motor vehicle safely. The final determination as to whether the individual listed in this form is physically qualified to drive a commercial motor vehicle will be made by the certifying medical examiner.

As the certifying medical examiner, I request that you review and complete this form, and return it to me via the individual, or at the mailing address, email address, or fax number specified below.

Printed Name of Certified Medical Examiner	*Signature of Certified Medical Examiner*
Date	*Email*
Phone Number	*Fax Number*
Street Address	*City, State, Zip Code*

Driver Name: _____

Non-Insulin-Treated Diabetes Mellitus Diagnosis

1. Date of diabetes mellitus diagnosis: _____
2. Medications - List all diabetes-related medications, dosage, and date treatment initiated *(attach additional pages if necessary)*

   Medication: _____ Dosage: _____ Date started: _____

   Medication: _____ Dosage: _____ Date started: _____

   Medication: _____ Dosage: _____ Date started: _____

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Blood Glucose Self-Monitoring

3. How many times per day is the individual testing blood glucose levels? _____
4. Is the individual compliant with glucose monitoring based on the individualized diabetes treatment plan?

   ☐ Yes ☐ No

Diabetes Management and Control

5. Has the individual been on a stable individualized diabetes treatment plan with good glucose control?

   ☐ Yes ☐ No

   If no, explain why not *(attach additional pages if necessary)*:

   _____

   _____

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6. Has the individual experienced any recent severe hypoglycemic episodes *(e.g., episodes requiring the assistance of others or resulting in loss of consciousness, seizure, or coma)*?

   ☐ Yes ☐ No

   If yes, provide date(s) of occurrence and associated details *(attach additional pages if necessary)*:

   _____

   _____

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7. Has the individual experienced any recent significant hyperglycemic episodes *(e.g., diabetic ketoacidosis and diabetic hyperglycemic hyperosmolar syndrome)*?

   ☐ Yes ☐ No

   If yes, provide date(s) of occurrence and associated details *(attach additional pages if necessary)*:

   _____

   _____

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Driver Name: _____

Hemoglobin A1c (HbA1c) Measurements

8. Has the individual had HbA1c measured intermittently over the last 12 months?

☐ Yes ☐ No

If yes, attach the most recent result. ATTACH FILE

Diabetes Complications

9. Does the individual have signs of diabetes complications or target organ damage?

a. Renal disease/renal insufficiency *(e.g., diabetic nephropathy, proteinuria, nephrotic syndrome)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

b. Cardiovascular disease *(e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

c. Neurological disease/autonomic neuropathy *(e.g., cardiovascular, gastrointestinal, genitourinary)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

d. Peripheral neuropathy *(e.g., sensory loss, decreased sensation, loss of vibratory sense, loss of position sense)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

e. Lower limb *(e.g., foot ulcers, amputated toes/foot, infection, gangrene)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

f. Other?

☐ Yes ☐ No

If yes, provide the condition, date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

Diabetic Retinopathy

10. Date of last eye examination: _____

11. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?

☐ Yes ☐ No

If yes, provide date of diagnosis: _____

Comments *(if necessary)*:

_____

_____

_____

I am the treating healthcare provider for the above individual.

☐ Yes ☐ No

Comments** (if necessary)**:

_____

_____

_____

Printed Name of Treating Healthcare Provider	*Signature of Treating Healthcare Provider*
Professional License Number and State	*Date*
Phone Number	*Email*
Street Address	*City, State, Zip Code*

Form MCSA-5871

OMB No.: 2126-0006
Expiration Date: 03/31/2028

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

VISION EVALUATION REPORT

Name: _____ **DOB:** _____

Driver's License Number: _____ **State:** _____

Information for the Individual:

The medical examiner must receive this report and begin the physical qualification examination not more than **45** calendar days after an ophthalmologist or optometrist signs this report.

Information for the Ophthalmologist or Optometrist:

This individual is being evaluated as part of the process to determine whether the individual meets the vision standard of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle in interstate commerce. This report is required to provide information for an individual who has "monocular vision," as defined by FMCSA, or did not meet FMCSA's vision standard at a physical qualification examination. An ophthalmologist or optometrist should complete this report to the best of the ophthalmologist's or optometrist's ability based on the evaluation of the individual and knowledge of the individual's medical history. The determination as to whether the individual meets the vision standard and is physically qualified to drive a commercial motor vehicle will be made by a medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines monocular vision as:

(1) in the better eye, distant visual acuity of at least 20/40 (with or without corrective lenses) and field of vision of at least 70 degrees in the horizontal meridian; and

(2) in the worse eye, either distant visual acuity of less than 20/40 with corrective lenses or field of vision of less than 70 degrees in the horizontal meridian, or both.

For general informational purposes only, to meet FMCSA's monocular vision standard, an individual must:

(1) have in the better eye distant visual acuity of at least 20/40 (Snellen), with or without corrective lenses, and field of vision of at least 70 degrees in the horizontal meridian;

(2) be able to recognize the colors of traffic signals and devices showing standard red, green, and amber;

(3) have a stable vision deficiency; and

(4) have had sufficient time pass since the vision deficiency became stable to adapt to and compensate for the change in vision.

Name: _____ **DOB:** _____

PLEASE CHECK/FILL IN REQUESTED INFORMATION (PLEASE PRINT):

1. I am: ☐ an ophthalmologist ☐ an optometrist

2. Date of vision evaluation *(MM/DD/YYYY)*: _____

3. Distant visual acuity (select N/A if there is no vision in an eye):
   Uncorrected: Right eye: 20/____ or N/A ☐ Left eye: 20/____ or N/A ☐
   Corrected: Right eye: 20/____ or N/A ☐ Left eye: 20/____ or N/A ☐
   Type of correction: ☐ Glasses ☐ Contacts

4. Field of vision, including central and peripheral fields, utilizing a testing modality that tests to at least 120 degrees in the horizontal. Formal perimetry is required. **Attach a copy of the formal perimetry test for each eye and interpret the results in degrees of field of vision.**
   Right eye: ____ degrees ("normal" or "full" are not acceptable)
   Left eye: ____ degrees ("normal" or "full" are not acceptable)
   Test used to determine results: _____ ATTACH FILE

5. Is the individual able to recognize the standard red, green, and amber traffic control signal colors? ☐ Yes ☐ No

6. Date of last comprehensive eye examination *(MM/DD/YYYY)*: _____ or ☐ Date unknown

7. Does the individual have monocular vision as it is defined by FMCSA? ☐ Yes ☐ No
   If yes, cause of the monocular vision (describe):
   _____
   _____

8. Date the monocular vision began *(MM/DD/YYYY)*: _____

9. Current treatment: _____ or ☐ N/A

10. Does the individual have any progressive eye condition or disease (e.g., macular edema, cataracts, glaucoma, or retinopathy)?
    ☐ Yes ☐ No
    If yes, provide the condition or disease, date of diagnosis, severity (mild, moderate, or severe), current treatment, and whether the condition is stable:
    a. Condition or disease: _____
    _____
    Date of diagnosis: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe
    Current treatment: _____
    Is condition stable? ☐ Yes ☐ No If no, why: _____

Name: _____ **DOB:** _____

b. Condition or disease: _____

_____

Date of diagnosis: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Current treatment: _____

Is condition stable? ☐ Yes ☐ No If no, why: _____

c. Condition or disease: _____

_____

Date of diagnosis: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Current treatment: _____

Is condition stable? ☐ Yes ☐ No If no, why: _____

11. In your medical opinion, is the individual's vision deficiency stable? ☐ Yes ☐ No

    If yes, provide the date the vision deficiency became stable *(MM/DD/YYYY)*: _____

12. In your medical opinion, has sufficient time passed since the vision deficiency became stable to allow the individual to adapt to and compensate for the change in vision and to drive a commercial motor vehicle safely?

    ☐ Yes ☐ No

13. In your medical opinion, is a vision evaluation required more often than annually? ☐ Yes ☐ No

    If yes, how often and why? _____

14. Additional comments *(attach additional pages as needed)*

_____

_____

_____

_____

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I attest that I am an ophthalmologist or optometrist and that the information provided is true and correct to the best of my knowledge.

Date	Printed Name and Medical Credential
Professional License Number and State	Signature
Phone Number	Email
Street Address	City, State, Zip Code