Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

____

(or sticker)

PRIVACY ACT STATEMENT: ***This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.***

AUTHORITY: Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

PURPOSE: To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State.

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].

ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses" (available at http://www.dot.gov/privacy/privacyactnotices).

ACKNOWLEDGMENT: ***I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.***

CMV Driver Signature: ______________________ Date: __________

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

PERSONAL INFORMATION

Last Name: ____________ First Name: ____________ Middle Initial: ___ Date of Birth: ________ Age: ___

Address: ______________________ City: ____________ State/Province: ___ Zip Code: ________

Driver's License Number: ______________________ Issuing State/Province: ___ Phone: ____________ Gender: ◯ M ◯ F

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 Yes/No: 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)

Last Name: ______ First Name: ______ Middle Initial: ____ DOB: ______ Exam Date: ______

DRIVER HEALTH HISTORY *(continued)*

Do you have or have your 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 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.

CMV Driver 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: ______ Middle Initial: ____ DOB: ______ Exam Date: ______

TESTING

Pulse rate: ______ Pulse rhythm regular: ◯ Yes ◯ No Height: ___ *feet* ___ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading (optional)		

Other testing if indicated

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.

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)

Updated Health History Questionnaire for D.O.T. & Pre-Employment Exams

Red Rock Chiropractic Center, Kyle J. Pankonin, D.C.

Date: | **Driver Title:** ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Prof. ☐Rev. | **Marital Status:** ☐Single ☐Married ☐Other

First Name | **"Nickname"** | **Last Name** | **Middle Name** | **Suffix** | **Social Security Number**

Cell Phone | **Home Phone** | **Email**

Best Contact Method: (choose one) ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email

Employment Status: (choose one) ☐ Employed ☐FT Student ☐PT Student ☐Other ☐Retired ☐Self-Employed

Race: **(Choose one)** ☐White ☐Black/African Amer. ☐Hispanic ☐Am. Indian/Alaskan Native ☐Asian ☐Other_________________ ☐I choose not to specify

Multi-Racial: (choose one) ☐No ☐Yes ☐Unknown ☐I choose not to specify

Ethnicity: (choose one) ☐Not Hispanic or Latino ☐Hispanic or Latino ☐I choose not to specify

Preferred Language: **(choose one)** ☐English ☐Spanish ☐ Other ______________________☐ I choose not to specify

Verification Question: (choose ONE, then give the answer to that question below) ☐What is the name of your favorite pet? ☐What city were you born in? ☐What high school did you attend? ☐What is your favorite movie? ☐What is your mother's maiden name? ☐What street did you grow upon? ☐What was the make of your first car? ☐What is your anniversary? ☐What is your favorite color?

Verification Answer (MUST be at least 6 characters):

Do you currently smoke tobacco of any kind? ☐Never ☐Former ☐Yes **If yes, how often do you smoke?** ☐Everyday ☐Somedays
How much do you smoke? ☐Less than 1 pack/day ☐1 pack/day ☐More than 1 pack/day **Please circle your level of interest in quitting.** 0 1 2 3 4 5 6 7 8 9 10

Primary Medical Doctor/Facility/City:

Current Medications: Please list current medications including dosage, if known. ☐I am currently not taking any medications.

Medication Name	Dosage & Frequency	Medication Name	Dosage & Frequency
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Medication Allergies: Please list any known allergies that you have to any medications. ☐I have no known medication allergies.

1.	3.
2.	4.

Do you have sleep apnea? ☐No ☐Yes **If yes, do you use a CPAP machine?** ☐No ☐Yes ☐Not sure

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ☐No ☐Yes ☐Not sure ☐Primary hypertension ☐Secondary hypertension

Has any doctor diagnosed you with Diabetes presently? ☐No ☐Yes ☐Not sure **If yes, what kind?** ☐Type I (Juvenile Onset) ☐ Type 2 (Adult Onset)
If yes, was your blood lab-work test for hemoglobin A1c>9.0% ☐No ☐Yes ☐Not sure

Chronic Health Problems: Briefly list the name of your problem(s)/condition(s). ☐I have no known chronic health problems.

1.	**3.**	**5.**	**7.**
2.	**4.**	**6.**	**8.**

Physical Limitations/Disabilities: Please list any physical limitations or disabilities you have. ☐I have no known physical limitations or disabilities.

1.	**3.**	**5.**	**7.**
2.	**4.**	**6.**	**8.**

Accidents, Injuries, Fractures, & Hospitalizations: Please list any previous accidents, injuries, fractures, & hospitalizations & approximate date of occurrence.

Accident & Date	Injury & Date	Fracture & Date	Hospitalization & Date
☐No previous accidents	☐No previous injuries	☐No previous fractures	☐No previous hospitalizations
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4	4	4.	4

Surgeries: Please mark any previous surgeries and list the approximate date of occurrence.

Surgery	Date	Surgery	Date
☐No previous surgeries		☐Laminectomies	
☐Appendectomy		☐Prostate surgery	
☐Cardiovascular procedure		☐Radical prostatectomy	
☐Cervical disc procedure		☐Other ___________________	
☐C-section		☐Other ___________________	
☐Gall bladder		☐Other ___________________	
☐Hysterectomy		☐Other ___________________	
☐Joint replacement		☐Other ___________________	

Have you had an x-ray or CT scan or MRI of your low back spine in the past 28 days? ☐No ☐Yes

Consent to Electronic Communication

I acknowledge the privacy risks associated with using Electronic communications and authorize Red Rock Chiropractic Center staff and/or doctor to communicate with me or any minor dependent/ward for purpose of medical advice, education, clinical record summaries, full medical records, and/or appointment reminders. I understand that my e-mail address will not be given to anyone outside of this clinic for any reason and that this will be for medical purposes only.

____________________________________   ____________________________________

Patient or Legal Guardian Signature   **Date**

OFFICE USE ONLY

☐Demographics ☐Labs ☐Ins. ☐Vitals ☐Smoking ☐ CT/X-ray/MRI ☐Meds ☐Allergy ☐Prob List ☐Clinic/Msgs ☐Submitted Online ☐Req. Info Faxed ☐Req. Info Received ☐Sent bill

Ht__________ **Wt**__________ **BP**___________ **Pulse**____________ **Grip Strength L** ______/R________ lbs. **BMI** ________ **O_2 saturation** _______**% Neck circumference**_______ inches

RELEASE OF INFORMATION

DOT & PRE-EMPLOYMENT EXAMS
Red Rock Chiropractic Center
202 Main St., P.O. Box 517, Lamberton MN 56152

Financial Responsibility:

☐ Company ☐ Employee

Have you had a DOT or pre-employment medical exam here previously?

☐ Yes ☐ No

Where did you hear about us?

☐ Employer ☐ Referral:______________________________ ☐ Other: ______________________________

Would you like an automatic reminder text before your DOT health card expires?

☐ No ☐ Yes, send to this cell number: ______________________________

EMPLOYER INFORMATION

COMPANY NAME	CONTACT PERSON

ADDRESS

TELEPHONE	FAX

Since it is not required, I understand that a copy of my examination will not be sent to my employer unless I request it by signing at the bottom of this form. **I also understand that failures will be automatically and immediately reported to my employer**. I understand that after April 2014, all results are required to be reported directly to the FMCSA.

SIGNATURE	DATE

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications

I have read and understand your Notice of Privacy Policy. A more complete description can be requested. I also understand that I can request, in writing that you restrict how my personal information is used and/or disclosed.

I authorize the release of all information obtained in this DOT and/or pre-employment medical exam to my employer as listed above.

SIGNATURE	DATE

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

PATIENT'S NAME ____
LAST FIRST MIDDLE INITIAL

ADDRESS ____
STREET CITY STATE ZIP

PHONE (_____)______________________ BIRTH DATE ________________ SSN________________________________

The following individual or organization is authorized to make the disclosure:

1.	2.	3.
NAME	NAME	NAME
ADDRESS	ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP	CITY STATE ZIP
PHONE NUMBER	PHONE NUMBER	PHONE NUMBER
FAX NUMBER	FAX NUMBER	FAX NUMBER

The type of information to be used or disclosed is as follows:

☒Assessment & Plan from most recent visit
☐Most recent medication list
☐Most recent blood pressure reading
☐CPAP machine compliance download
☐Other_______________________________

☐Most recent eye examination
☐Most recent diabetic retinopathy screen
☐ Most recent A1c and fasting glucose results
☐Most recent audiometric test
☐Other_______________________________

☐Sleep study test results
☐Exercise tolerance/stress test results
☐Clearance from cardiologist (see attached)
☐Medication clearance (see attached)
☐Other_______________________________

This information may be disclosed to and used by the following organization:

KYLE J. PANKONIN, D.C.
RED ROCK CHIROPRACTIC CENTER
202 MAIN STREET
PO BOX 517
LAMBERTON, MN 56152
PHONE: 507-752-7650
FAX: 507-752-7635

The reason for disclosure of this information is for the following reason:

☒ Continued Healthcare ☒ Medical fitness for duty determination (DOT or pre-employment physical)

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the medical record department. I understand the revocation will not apply to:

- Information already released in response to this authorization
- My insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
Unless otherwise revoked, this authorization will expire on the following date, event, or condition:________________. If I fail to specify an expiration date, event, or condition, this authorization will be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

SIGNED ____ DATE_______________________________
(IF NOT PATIENT, STATE RELATIONSHIP)