THIS FORM IS TO BE GIVEN TO THE DRIVER'S PRIMARY CARE PHYSICIAN/NP/PA OR SPECIALIST ONLY IF THERE ARE CONCERNS THAT THE DRIVER WILL NOT BE MEDICALLY CLEARED AT THE DOT PHYSICAL APPOINTMENT.

This form is meant to help those drivers who have medical conditions and want to provide additional documentation to the DOT Medical Examiner about their health status, to increase the likelihood of being medically cleared for a commercial driver's license.

Driver's Name _____

Date of Birth _____

Date of DOT Appointment at Olde Towne _____

THIS SECTION IS TO BE FILLED OUT BY THE DRIVER

I authorize my physicians or other medical providers to release medical information to clinical staff at Olde Towne Medical Center that is relevant to my DOT physical for a Commercial Driver's License.

Driver's Signature _____

Date _____

THE SECTIONS BELOW NEED TO BE FILLED OUT BY A PHYSICIAN, NP OR PA

The above named individual will be seen or was seen in our office for a Department of Transportation (DOT) Medical Certification Examination. In the interest of public safety, the certifying medical examiner is required to certify that the driver does not have any medical conditions or diagnoses that that may affect the driver's ability to safely operate a commercial motor vehicle.

This driver has reported a history of the following condition(s):

__ **Hypertension** (Documentation of a blood pressure reading of 140/90 or below at a medical visit within 45 days of the driver's exam and/or longer term trends will assist in medical clearance of the driver).

__ **Diabetes**

__ **Mental health diagnoses**

__ **Other relevant diagnoses (please specify)** _____

As the treating medical doctor, nurse practitioner or physician's assistant identified by this driver, we are asking you to

1) **sign in the box below to certify your medical opinion of whether your patient is safe or not safe to drive a commercial motor vehicle**

2) attach a current list of medications prescribed to this individual and/or relevant records **IF** you would like.

Based on my knowledge of this individual's medical condition(s), in my medical opinion, this individual is safe to drive a commercial motor vehicle per DOT standards.

__ Yes __ No

MD/NP/PA Signature _____ Date _____

Print Name _____ Phone _____

Practice Address _____

This form can be faxed to Olde Towne or given to the driver.

Olde Towne Medical & Dental Center
5249 Olde Towne Road, Williamsburg, VA 23188
Phone: 757-259-3258
Fax: 757-220-1953
ww.otmdc.org/dot-physicals