

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: Medical Programs Division, Federal Motor Carrier Safety Administration, 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)

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

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/ _____	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors ☐ Yes ☐ No

Monocular vision ☐ Yes ☐ No

Referred to ophthalmologist or optometrist? ☐ Yes ☐ No

Received documentation from ophthalmologist or optometrist? ☐ Yes ☐ No

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

Record distance (in feet) from driver at which a forced whispered voice can first be heard

Right Ear Left Ear

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
1. General	☐	☐
2. Skin	☐	☐
3. Eyes	☐	☐
4. Ears	☐	☐
5. Mouth/throat	☐	☐
6. Cardiovascular	☐	☐
7. Lungs/chest	☐	☐

Body System

	Normal	Abnormal
8. Abdomen	☐	☐
9. Genito-urinary system including hernias	☐	☐
10. Back/spine	☐	☐
11. Extremities/joints	☐	☐
12. Neurological system including reflexes	☐	☐
13. Gait	☐	☐
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): Nicholas R. Weber

Medical Examiner's Address: 909 S. Union Street City: Rock Rapids State: IA ☒ Zip Code: 51246

Medical Examiner's Telephone Number: (712) 472-4732 Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: 007241 Issuing State: IA ☒

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

☐ Other Practitioner (specify): _____

National Registry Number: 1431892008

Medical Examiner's Certificate Expiration Date:

HIPAA Notice of Privacy Practices

Lyon County Chiropractic
909 S. Union St.
Rock Rapids, IA 51246
Phone: (712) 472-4732
Fax: (712) 472-4734

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, our protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to your and when required by the Secretary of the department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations, you may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____