DOT Diabetes Guidelines

Patient Name: ___________________________________ Date of Birth: __________________

Provider: _______________________________________ Date of Physical: ________________

The above named patient has reported a history of the following condition:

☐ Type II Diabetes Mellitus ☐ Peripheral Neuropathy ☐ Diabetic Retinopathy

To comply with DOT guidelines the condition (s) must be adequately controlled with diet or oral medications, and cannot be treated with insulin unless given an insulin waiver.

Please complete the following and return with copy of HbA1c:

1. Diagnosis:
2. Date of last exam:
3. Medication (s):
4. Most recent HbA1c (copy needed)
5. Severe hypoglycemic reaction in the past 12 months?

   Please circle one: Yes No

   Details:

Healthcare provider statement: *In the interest of public safety the certifying medical examiner is required to certify that the driver does not have any physical, mental, or organic defect of such a nature as to affect the driver's ability to safely operate a commercial motor vehicle.* Based on your knowledge of this individual's medical condition, do you feel he/she is compliant with the treatment plan and condition is controlled to safely operate a commercial motor vehicle?

Please circle one: Yes No

Physician's signature: __________________________________ Date: ________________

Printed name: ____

Phone number: _______________________________________

Thank you for providing the above information. Please attach a copy of the requested results and fax this form and results to MedStat.

I authorize your office to release the above medical information to MedStat.

Patient Signature: ___________________________ Printed name: ______________________

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