MedStat
Lutheran Health Network

Patient Name: _____ Date of Birth: _____

Provider: _____ Date of Physical: _____

To be completed by: _____

The above named individual was seen at our clinic for a Department of Transportation (DOT) Medical Certification Examination. The medical history and/or examination is significant for:

☐ Hypertension ☐ Depression ☐ Diabetic History

☐ Other: _____

As the certifying examiner, we have the medical clearance for this individual "on-hold" pending additional documentation from the current healthcare provider regarding this condition. To assist us in the DOT medical certification process, the following information is requested regarding this individual's medical status.

1. Diagnosis(es):

2. Date of last examination(s):

3. Dates and results of special studies:

4. Treatment given, including medications and dosages:

5. Any restrictions or limitations:

**Healthcare provider opinion:** *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 this individual is compliant and asymptomatic with adequate control?

**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.

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

Patient Signature: _____ Printed Name: _____

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Phone: ▪ Fax: