DOT Cardiac/PCI/Rhythm Control Clearance

Patient Name: _____ **Date:** _____

RE: Supporting Medical Information Requested

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

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. *(additional criteria may be attached)

As the certifying examiner, we have the medical clearance for the individual currently in "determination pending" status, while awaiting documentation from the cognizant 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 (use back or additional sheets if necessary):

Diagnosis(es): _____

Per DOT recommendations the following criteria must be met to be considered qualified to drive:

1. Examination and approval by the treating cardiologist.
2. Asymptomatic.
3. Exercise Treadmill Test (ETT) three to six months post intervention. In the CMV driver this requires exercising to workload capacity of at least six METS (through Bruce Stage II or equivalent), attaining a heart rate > 85% of predicted maximum (unless no significant ST segment depression or elevation). Stress radionuclide or echocardiography imaging should be performed for symptomatic individuals, individuals with an abnormal resting echocardiagram, or those drivers who fail to obtain the minimal standards required from the standard ETT.
4. Annual medical qualification.
5. Negative ETT at least every other year (criteria above) and tolerance of all cardiovascular medication. The driver should not experience orthostatic symptoms, including light-headedness; resting SBP <95 mm Hg; or a systolic blood pressure decline > 20 mm Hg upon standing.
6. If on Coumadin - recent PT/INR and compliance with regimen.
7. No MI less than two months prior.
8. Ejection fraction >40%.

Based on my knowledge of this individual's medical condition, in my medical opinion, this individual meets the above *criteria: ☐ **Yes** ☐ **No**

Physician Signature: _____ Date: _____

Physician Name - Print: _____ Phone Number: _____

Thank you for providing the above information. Please return this document to our secure fax line at 812-478-4178.

Contact us with any questions at 812-238-7788.

Sincerely,

I authorize _____ to release the above medical information to Union Hospital Center for Occupational Health.

Signature: _____

Name-Print: _____

Date: _____