DOT General Medical 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:

The individual needs clearance for the following:

- ☐ Personal Medication(s): _____
- ☐ Cardiovascular Disorder(s): _____
- ☐ Neurological Condition(s): _____
- ☐ Other Condition(s): _____

In the interest of public safety, we as the certifying medical examiners are 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, I have the medical clearance for this driver currently in "determination pending" status, while awaiting additional documentation from you, the treating healthcare provider, regarding this condition. To assist me 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): _____

Date of examination(s): _____
Dates and results of special studies: _____

Treatment given, including medications and dosages: _____

Any restrictions or limitations: _____

Date of next examination: _____

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 our DOT Coordinator 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: _____