DOT High Blood Pressure 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: **High Blood Pressure**

In the interest of public safety, the certifying medical examiner is required to certify that the driver does not have any phsyical, 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 additional documentation from the appropriate 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):

*The driver has been advised that he/she **must** return to our clinic for a final blood pressure reading as well, with a Certified Medical Examiner per DOT guidelines.

Per DOT receommendations, a driver may be considered qualified to drive with a diagnosis of Hypertension if at least **one separate reading performed at a Provider's office other than that of the Certifying Medical Examiner, which is stable and less than Stage 1 criteria per JNC VII guidelines (<140/90).**

Date: _____ Blood Pressure Reading: _____

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: _____