History of Substance Abuse 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):

1. Does the patient have any clinical evidence or do you have any personal knowledge of patient's addiction or habituation to drugs/alcohol? No___ Yes___
   Indicate substance(s) and duration of addiction: ____________________________________
2. Has patient been subject to residential treatment or hospitalization for this condition? No___Yes___
3. Is the patient currently under therapy? No___ Yes___ Where? _____________________
   Duration and frequency of therapy: ____
4. Is there evidence of physical complication(s) from drug/alcohol use or abuse: No___ Yes___
   Please explain: ____
   ____
   ____
5. Has patient been advised to abstain from addicted substance(s)? No___ Yes___
6. Has patient followed your recommendations for treatment and therapy? No___ Yes___
7. Has patient been prescribed antabuse? No___ Yes___
8. Is the patient's antabuse therapy monitored? No___ Yes___
   By whom and frequency: ____
   Has a period of abstinence or control been established? Please describe:
   ____
   ____
9. What is your prognosis for this condition?
   ____
   ____
10. Is the patient currently on Methadone therapy? No___ Yes___

History of Substance Abuse Clearance

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: ______________________________