Endocrinologist Annual Evaluation Checklist

Federal Diabetes Exemption Program

Driver Identifying Information

Name: _____
First MI Last

Address: _____

DOB (MM/DD/YYYY): _____

This applicant was granted an exemption from the Federal diabetes standard to operate a commercial motor vehicle (CMV) in interstate commerce. ANNUAL medical monitoring and reporting is a condition of the exemption from the diabetes standard of 49 CFR 391.41(b)(3).

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

1. ☐ I am board-certified in endocrinology.

   ☐ I am board-eligible in endocrinology.

If neither, do not continue your assessment. Applicants must be evaluated by an endocrinologist who is board-certified or board-eligible.

2. Office telephone number: _____

3. Office fax number: _____

4. Date of examination (MM/DD/YYYY): _____

5. I have reviewed the patient's daily glucose logs (from his/her glucose monitoring device).
   ☐ YES ☐ NO

6. I have compared monitoring dates to his/her driving log to ensure that the individual is checking glucose levels prior to operating a CMV as required.
   ☐ YES ☐ NO
   If **NO**, please comment: _____

7. I certify that this individual's glucose levels have been maintained in the range of 100 to 400 mg/dl while driving a CMV.
   ☐ YES ☐ NO ☐ N/A

8. I certify that this individual continues to maintain a stable insulin regimen and that his/her glycosylated hemoglobin (A1C) result continues to reflect stable control of his/her insulin-treated diabetes mellitus (ITDM).

☐ YES ☐ NO

9. FMCSA defines **a severe hypoglycemic reaction** as one that results in:

Seizure, or loss of consciousness, or
Requiring assistance of another person, or
Period of impaired cognitive function that occurred without warning.

In the last 12 months, while being treated for diabetes, has the patient had a severe hypoglycemic episode? ☐ YES ☐ NO

If yes, provide information on each hypoglycemic episode:
Date(s):

_____

Include additional information about each episode including symptoms of hypoglycemic reaction, treatment, and suspected cause:

_____
_____
_____

Was the patient hospitalized? ☐ YES ☐ NO

If yes, provide brief summary of hospitalization:

_____
_____
_____

Has the patient's treatment regimen changed since the last hypoglycemic episode?

☐ YES ☐ NO

Briefly explain changes:

_____
_____
_____
_____

10. Has the patient continued to receive education in the management of diabetes that includes diet, monitoring, recognition and treatment of hypoglycemia and hyperglycemia?

☐ YES ☐ NO

If yes, please provide last education date (MM/YYYY): _____

Note: The applicant must participate in a diabetes education program at least annually to remain in the diabetes exemption program.

11. I hereby certify that in my medical opinion, this applicant understands how to individually manage and monitor his/her diabetes mellitus. ☐ YES ☐ NO

12. Please describe the **progression** in diabetes complications/end organ diseases that have occurred in the **past year**: (***if none, write none***)

a) **Renal disease** _____
_____

b) **Cardiovascular disease** _____
_____

c) **Neurological disease** _____
_____

Autonomic neuropathy ☐ YES ☐ NO
(i.e, cardiovascular GI, GU)

Peripheral Neuropathy ☐ YES ☐ NO
(If YES, circle below)
Sensory
Decreased sensation
Loss of vibratory sense
Loss of position sense

13. Has the patient **developed** any of the following complications within the past year (please check *yes* or *no*):

Renal Disease	Renal insufficiency	☐ YES	☐ NO
	Proteinuria	☐ YES	☐ NO
	Nephrotic Syndrome	☐ YES	☐ NO
Cardiovascular Disease	Coronary artery disease	☐ YES	☐ NO
	Hypertension	☐ YES	☐ NO
	Transient ischemic attack	☐ YES	☐ NO
	Stroke	☐ YES	☐ NO
	Peripheral vascular disease	☐ YES	☐ NO
Neurological Disease	Autonomic neuropathy (i.e, cardiovascular GI, GU)	☐ YES	☐ NO
	Peripheral Neuropathy (Circle below) Sensory Decreased sensation Loss of vibratory sense Loss of position sense	☐ YES	☐ NO

Comments:

_____

_____

14. List all medications including those taken related to the treatment of diabetes (if none, write none):

Name of Medication	**Dose**	**Reason for Taking the Medication**

15. In your medical opinion, does any one of the listed medications have the potential to compromise the driver's ability to operate a CMV safely?

☐ YES ☐ NO

If yes, which medication(s): _____

_____

16. In my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage their diabetes. ☐ YES ☐ NO

17. I hereby certify that in my medical opinion, the applicant is able to use insulin while safely operating a commercial motor vehicle (large truck or motor coach) in interstate commerce while using insulin. ☐ YES ☐ NO

18. **Please attach a copy of your office letterhead with your printed/typed name, signature, date, medical license number, and state of issue to this checklist.**

Please send this completed annual endocrinology checklist to:

Diabetes Exemption Program
1200 New Jersey Ave., SE
Room W64-224
Washington, DC 20590

If you have questions or need additional information, please call (703) 448-3094.

Vision Annual Evaluation Checklist

Federal Diabetes Exemption Program

Driver Identifying Information

Name: _____
First MI Last
Address: _____

DOB (MM/DD/YYYY): _____/_____/_____

This individual was granted an exemption from the Federal diabetes standard to operate a commercial motor vehicle (CMV) in interstate commerce. Annual medical monitoring and reporting is a condition of the exemption from the diabetes standard of 49 CFR 391.41(b)(3). <u>An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).</u>

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

1. ☐ I am an ophthalmologist ☐ I am an optometrist

2. Date of most recent examination: _____/_____/_____

3. Distant visual acuity (**please provide both if applicable**):

	☐ UNCORRECTED	☐ CORRECTED ☐Glasses ☐Contact Lens
Right eye:	20/_____	20/_____
Left eye:	20/_____	20/_____

4. Field of vision (FOV)*:
   Please record the interpreted results in degrees of horizontal field of vision for each eye. The terms "normal" or "full" are not acceptable responses.

   Right eye: _____degrees

   Left eye: _____degrees

   Test used to determine: _____

*__Note:__ If the patient has received laser treatment, and in your medical opinion you believe the patient's FOV is compromised, FMCSA recommends formal perimetry to determine if the driver meets the FOV standard.

5. Does the patient have diabetic retinopathy? ☐ YES ☐ NO

   If yes: ☐ Proliferative
   ☐ Stable ☐ Unstable
   ☐ Nonproliferative
   ☐ Stable ☐ Unstable

   Treatment: _____

   Date diagnosed: _____

   Surgery/procedures: _____

   Requires recheck in ____ months

6. Does the patient have macular edema?
   ☐ YES ☐ NO

   ☐ Stable ☐ Unstable

   Requires recheck in ____ months

7. Does the patient have cataract(s)?
   ☐ YES ☐ NO

   ☐ Stable ☐ Unstable

   Requires recheck in ____ months

8. Does the patient have any other medical diagnosis related to vision?
   ☐ YES ☐ NO

   If yes, what? _____

   ☐ Stable ☐ Unstable

   Requires recheck in ____ months

9. **Please attach a copy of your office letterhead with your printed/typed name, signature, date, medical license number, and state of issue to this checklist.**

Please send this completed annual vision checklist to:

Diabetes Exemption Program
1200 New Jersey Ave., SE
Room W64-224
Washington, DC 20590

If you have questions or need additional information, please call (703) 448-3094.