Endocrinologist Evaluation Checklist

Federal Diabetes Exemption Program

Driver Identifying Information

Name: _____
First MI Last

Address: _____

DOB (MM/DD/YYYY): _____

This applicant is applying for a Federal diabetes exemption to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in interstate commerce. Part of the application process is an evaluation by a board-certified or board-eligible Endocrinologist to determine if the individual has any medical problem related to diabetes that might impair safe driving.

The applicant's examination by an Endocrinologist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

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 most recent patient evaluation (MM/DD/YYYY): _____
(Note: the applicant must have been on insulin daily for a minimum of 30 to 60 days prior to the completion of this evaluation. See13.A)

5. I am familiar with the patient's medical history for the past 5 years through a records review, treating the patient, or consultation with the treating physician.
   ☐ YES ☐ NO

A review of the applicant's 5-year medical history is required. If the history is not available, please state the reason.

_____
_____
_____

6. Date of initial diagnosis of diabetes mellitus: _____

   Treatment for diabetes mellitus prior to insulin use:
   ☐ None ☐ Diet ☐ Oral agent

7. Insulin Usage:
   Date insulin use began: _____
   Type of insulin(s) and current dosage now used: _____
   _____
   Length of time on current dose: _____
   Is the applicant compliant with his/her insulin regimen? ☐ YES ☐ NO

   If patient uses insulin pump, current average daily dose: _____

8. 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 5 years, while being treated for diabetes, has the patient had recurrent (2 or more) severe hypoglycemic episodes? ☐ YES ☐ NO

In the last 12 months, while being treated for diabetes, has the patient had a severe hypoglycemic episode? ☐ YES ☐ NO (**If no proceed to #9 below**)

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:

_____
_____
_____

9. Additional Information or History (If none, write *none*.):

_____

_____

_____

_____

10. 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**

11. In your medical opinion, **other than insulin**, 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): _____

_____

12. Associated Medical Conditions (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	☐ YES	☐ NO
	(Circle one below)		
	Sensory		
	Decreased sensation		
	Loss of vibratory sense		
	Loss of position sense		

If the applicant has been or is currently being treated for any of the above medical conditions, provide relevant additional information (consultation notes, special studies, follow-up reports, and hospital records).

13. Stable Insulin Regimen/Glucose Measurements:

A. Background and criteria:
The driver should have stable control and minimal risk of hypoglycemia and hyperglycemia while operating a CMV.

<u>30 day requirement</u>: An individual diagnosed with diabetes mellitus who had been previously treated with oral medication, and who now requires insulin, should have at least a 1-month period on insulin to establish stable control.

<u>60 day requirement</u>: An individual newly diagnosed with diabetes mellitus, who is now starting insulin, should have at least a 2-month period on insulin to establish stable control.

B. Glucose Measurements:

A CMV driver **should not have large fluctuations in blood glucose levels. The determination of a patient's stable control is left to the treating endocrinologist.**

a. I have reviewed the patient's daily glucose monitoring logs while using insulin.
☐YES ☐NO

b. Does the patient have any large fluctuations that may impact safe driving?
☐YES ☐NO

14. Since beginning insulin use, has the patient received 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 apply for and remain in the diabetes exemption program.

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

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 safely operate a commercial motor vehicle (large truck or motor coach) in interstate commerce while using insulin. ☐ YES ☐ NO

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

Vision Evaluation Checklist
Federal Diabetes Exemption Program

Driver Identifying Information

Name: _____
First MI Last

Address: _____

DOB (MM/DD/YYYY): _____

This applicant is applying for a Federal diabetes exemption to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in interstate commerce. Part of the application process is an eye examination by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving. NOTE: If the applicant has retinopathy, an ophthalmologist examination is required.

The applicant's examination by an ophthalmologist or an optometrist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

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

2. Date of most recent patient examination: _____ (MM/DD/YYYY)

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

   Visual Acuity ***without*** Corrective Lenses: Right Eye: 20/ Left Eye: 20/

   Visual Acuity ***with*** Corrective Lenses: Right Eye: 20/ Left Eye: 20/
   ☐ Glasses
   ☐ Contact Lens

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. Color Vision:

Is the patient able to identify correctly the standard red, green, and amber traffic control signal colors? ☐YES ☐NO

Note: If color testing results are inconclusive, it is discretionary whether to administer a controlled test using an actual traffic signal to determine the individual's ability to recognize red, green, and amber.

An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).

6. 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

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

8. Does the patient have cataracts?
☐ YES ☐NO

9. Does the patient have any other medical diagnosis, visual defects, condition or field loss that would affect the safe operation of a motor vehicle?
☐ YES ☐NO

If yes, what? _____

10. If yes to any of the conditions listed above, are any unstable?
☐ YES ☐NO

If yes, which condition(s)? _____

11. In your medical opinion, is monitoring required more often than annually?
☐ YES ☐NO

If yes, how often? _____

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