

Las Vegas Urgent Care®

Medical Examination Report

FOR COMMERCIAL DRIVER FITNESS DETERMINATION

1. DRIVER'S INFORMATION		Driver completes this section					Date of Exam	
Driver's Name (Last, First, Middle)		Social Security No.	Birth Date	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> New Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Follow Up	License Class <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Other <input type="checkbox"/> CDL	
Address:	City, State, ZIP Code	Telephone:	Driver's License No.			State of Issue		

2. HEALTH HISTORY			Driver completes this section, but medical examiner is encouraged to discuss with driver.		
Yes No <input type="checkbox"/> <input type="checkbox"/> Any illness or injury in last 5 years? <input type="checkbox"/> <input type="checkbox"/> Head/Brain injuries, disorders or illnesses <input type="checkbox"/> <input type="checkbox"/> Seizures, epilepsy - If Yes, list medications: _____ <input type="checkbox"/> <input type="checkbox"/> Eye disorders or impaired vision (except corrective lenses) <input type="checkbox"/> <input type="checkbox"/> Ear disorders, loss of hearing or balance <input type="checkbox"/> <input type="checkbox"/> Heart disease or heart attack; other cardiovascular condition If Yes, list medications: _____ <input type="checkbox"/> <input type="checkbox"/> Heart surgery (valve replacement/bypass, angioplasty, pacemaker) <input type="checkbox"/> <input type="checkbox"/> High blood pressure - If Yes, list medications: _____ <input type="checkbox"/> <input type="checkbox"/> Muscular disease	Yes No <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis <input type="checkbox"/> <input type="checkbox"/> Kidney disease, dialysis <input type="checkbox"/> <input type="checkbox"/> Liver disease <input type="checkbox"/> <input type="checkbox"/> Digestive problems <input type="checkbox"/> <input type="checkbox"/> Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> diet <input type="checkbox"/> pills <input type="checkbox"/> insulin <input type="checkbox"/> <input type="checkbox"/> Nervous or psychiatric disorders, e.g., severe depression If Yes, list medications: _____ <input type="checkbox"/> <input type="checkbox"/> Loss of, or altered consciousness <input type="checkbox"/> <input type="checkbox"/> Surgery	Yes No <input type="checkbox"/> <input type="checkbox"/> Fainting, dizziness <input type="checkbox"/> <input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring <input type="checkbox"/> <input type="checkbox"/> Stroke or paralysis <input type="checkbox"/> <input type="checkbox"/> Missing or impaired hand, arm, foot, leg, finger, toe <input type="checkbox"/> <input type="checkbox"/> Spinal injury or disease <input type="checkbox"/> <input type="checkbox"/> Chronic low back pain <input type="checkbox"/> <input type="checkbox"/> Regular, frequent alcohol use Narcotic or habit forming drug use <input type="checkbox"/> <input type="checkbox"/> Chronic Pain Medication or Chronic Anxiety Medication			

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate. I authorize Las Vegas Urgent Care to provide all or any of my medical records to my employer and release Las Vegas Urgent Care, its employees, physicians, nurses, technicians and any other employee from any and all liabilities, claims, or causes of action that may result from this authorization. I understand paying for this medical assessment does not guarantee meeting (passings) standards set by CFR and assessment is a non refundable service that must be reported to FMCSA.

Driver's Signature

Date

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

Testing (Medical Examiner completes Section 3 through 7)

3. VISION	Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.
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INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. **Monocular drivers are not qualified.**

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	°

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? Yes No

Applicant meets visual acuity requirement only when wearing: Corrective Lenses

Monocular Vision: Yes No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination	Name of Ophthalmologist or Optometrist (Print)	Tel No.	License No/State of Issue	Signature
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4. HEARING	Standard: a) Must first perceive forced whispered voice >= 5 ft., with or without hearing aid, or b) average hearing loss in better ear <= 40 dB <input type="checkbox"/> Check if hearing aid used for tests <input type="checkbox"/> Check if hearing aid required to meet standard.
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INSTRUCTIONS: To convert audiometric test results from ISO to ANSI. -14 dB from ISO for 500Hz, -10 dB for 1,000Hz, -8.5 dB for 2,000Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical reading must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear	Left Ear	b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI Z24.5-1951)			
	\ Feet	\ Feet				
	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
	Average:			Average:		

5. BLOOD PRESSURE / PULSE RATE	Numerical readings must be recorded. Medical examiner should take at least 2 readings to confirm blood pressure.
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Blood Pressure	Systolic	Diastolic	Reading	Category	Expiration Date	Recertification
Driver qualified if <= 140/90.			140-159/90-99	Stage 1	1 year	1 year if <= 140/90 One-time certificate for 3 months if 141-159/91-99
Pulse Rate : <input type="checkbox"/> Regular <input type="checkbox"/> Irregular			160-179/100-109	Stage 2	One-time certificate for 3 months	1 year from date of exam if <= 140/90
Record Pulse Rate:			>= 180/110	Stage 3	Disqualified 6 months from date of exam if <= 140/90	6 months if <= 140/90

Driver's Name (Last, First) _____

Date of Exam _____

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Date of Birth _____

6. LABORATORY AND OTHER TEST FINDINGS Numerical reading must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

URINE SPECIMEN	SP. GR	PROTEIN	BLOOD	SUGAR

Other Testing (Describe and record) _____

7. PHYSICAL EXAMINATION Height _____ (in.) Weight _____ (lbs) BMI _____ Neck Circ _____ (in)

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving. Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See Instructions To The Medical Examiner for guidance.

BODY SYSTEM	CHECK FOR:	YES *	NO	BODY SYSTEM	CHECK FOR:	YES *	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.			7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.			8. Vascular	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.			9. Genito-urinary	Hernias.		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing			10. Extremities - Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.			11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or xray of chest.			12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		

* COMMENTS: (explain all YES answers): _____

Note certification status here. See Instructions to the Medical Examiner for guidance.

- Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
- Does not meet standards
- Meets standards, but periodic evaluation required.

- Wearing corrective lenses
- Wearing hearing aid
- Accompanied by a _____ waiver/exemption. Driver must present exemption at time of certification. Exemption explanation (if Other) _____
- Skill Performance Evaluation (SPE) Certificate
- Driving within an exempt intracity zone. (See 49 CFR 391.62)
- Qualified by operation of 49 CFR 391.64

Due to _____ driver qualified only for:

- 3 months
- 6 months
- 1 year
- Other _____

- Temporarily disqualified due to (condition or medication): _____
- Return to medical examiner's office for follow up on _____

Location: Las Vegas Urgent Care 2901 N Tenaya Way, Suite 200 Las Vegas, NV 89128

Telephone Number (702) 852-2000

If meets standards, complete a Medical Examiner's Certificate according to 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)

SIGNATURE OF MEDICAL EXAMINER	MEDICAL CERTIFICATE EXPIRATION DATE	<input type="checkbox"/> Intrastate Only
MEDICAL EXAMINER'S NAME (PRINT) <input type="checkbox"/> Ralph Carullo, MD <input type="checkbox"/> Fauzia Carullo, MD	<input checked="" type="checkbox"/> MD <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Chiropractor <input type="checkbox"/> DO <input type="checkbox"/> Advance Practice Nurse <input type="checkbox"/> Other Practitioner	
MED EXAMINER'S LICENSE OR CERT NO / ISSUING STATE <input type="checkbox"/> 13661 NV <input type="checkbox"/> 13682 NV	NATIONAL REGISTRY NO.	

- Update to previously transmitted exam

UPDATES / FOLLOW UP

DATE	COMMENT	MED EXAM CERT EXPIRATION DATE	EXAMINER

PRINT