

Employer Name: _____		Medical Examination Report Non-DOT Fitness Determination				Clinic: _____	
1. APPLICANT INFORMATION		Reason For Test:		Birthdate	Age	Gender	Date of Exam
Applicant's Name (Last, First, Middle)		Social Security Number		Driver's License #		License Class ☐ A ☐ B ☐ C ☐ D ☐ Other	
Address		City, ST, Zip		Phone Day: _____ Evening: _____		State of Issue	
2. Health History							
Applicant completes this section, but medical examiner is encouraged to discuss with patient.							
		Yes	No	Yes	No	Yes	No
1 Any illness or injury in the last 5 years?		☐	☐	13 Liver disease	☐	☐	☐
2 Head/Brain injuries, disorders or illnesses?		☐	☐	14 Digestive problems	☐	☐	☐
3 Seizures, epilepsy		☐	☐	15 Diabetes or elevated blood sugar controlled by	☐	☐	☐
Medication ☐				Diet ☐ Pills ☐ Insulin ☐			
4 Eye Disorders or impaired vision (except corrective lenses)		☐	☐	16 Nervous or psychiatric disorders, e.g., severe depression	☐	☐	☐
5 Ear disorders, loss of hearing or balance		☐	☐	Medication ☐			
6 Heart disease or heart attack; other cardiovascular condition		☐	☐	17 Loss of, or altered consciousness	☐	☐	☐
Medication ☐				18 Fainting, dizziness	☐	☐	☐
7 Heart surgery (valve replacement/bypass, angioplasty, pacemaker)		☐	☐	19 Sleep disorders, sleep apnea, loud snoring	☐	☐	☐
8 High Blood Pressure		☐	☐	20 Stroke or paralysis	☐	☐	☐
Medication ☐				21 Missing or impaired hand, arm, foot, leg, finger, toe	☐	☐	☐
9 Muscular disease		☐	☐	22 Spinal injury or disease	☐	☐	☐
10 Shortness of breath		☐	☐	23 Chronic low back pain	☐	☐	☐
11 Lung disease, emphysema, asthma, chronic bronchitis		☐	☐	24 Regular, frequent alcohol use	☐	☐	☐
12 Kidney disease, dialysis		☐	☐	25 Narcotic or habit forming drug use	☐	☐	☐
For any YES answer, indicate onset date, diagnosis, treating physician's name, 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.							
Applicant's Signature				Date			
Medical Examiner Comments							

TESTING (Medical Examiner completes Section 3 through 8)

Employer Name: _____

Applicant Name: _____

3. VISION

The use of corrective lenses should be noted.

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 a denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If applicant habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious.

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 ☐ N/A

4. HEARING

☐ Check if hearing aid used for tests.

Instructions: To convert automatic test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be provided. Complete either Section A or B

a) Record distance from individual at which forced whispered voice can first be heard.

Right Ear	Left Ear	feet
feet	feet	feet

b) If audiometer is used, record hearing loss in decibels.
 (acc. To ANSI Z24.5-1951)

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average:			Average:		

5. BLOOD PRESSURE / PULSE RATE

Numerical readings must be recorded.

Blood Pressure	Systolic	Diastolic

Pulse Rate: ☐ Regular ☐ Irregular
Record Pulse Rate:

6. LABORATORY & OTHER FINDINGS

Numerical readings must be recorded. Enter N/A if Urinalysis is not indicated.

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

Urine Specimen	Sp.Grav.	Protein	Blood	Sugar

Other testing (Describe and record):

Employer Name: _____		Applicant Name: _____	
7. PHYSICAL EXAMINATION			
Height: _____		Weight: _____	BMI: _____
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.			
BODY SYSTEM	CHECK FOR:		YES NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.		☐ ☐
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.		☐ ☐
3. Ears	Middle ear disease, occlusion of external canal, perforated eardrums.		☐ ☐
4. Mouth & Throat	Irreparable deformities likely to interfere with breathing or swallowing.		☐ ☐
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.		☐ ☐
6. Lungs and Chest	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezing or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may lead to pulmonary tests or a chest x-ray.		☐ ☐
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		☐ ☐
8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		☐ ☐
9. Genito-urinary System	Hernias		☐ ☐
10. Extremities	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp & prehension in upper limb to maintain steering wheel grip. Insufficient mobility & strength in lower limb to operate pedals properly.		☐ ☐
11. Spine, Musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		☐ ☐
12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar & Babinski's reflexes, ataxia.		☐ ☐
Examiner Comments:			

Employer Name: _____ Applicant Name: _____

8. Exam Result Status

Based upon the health assessment, the above applicant/employee has been physically examined and pertinent medical history has been reviewed.

Examination Type

☐ Pre-employment/Pre-placement ☐ Periodic ☐ Exit ☐ Other

Based upon this health assessment and knowledge of job requirements:

☐ As provided by the employer ☐ As described by the applicant/employee

Recommendations

The following recommendations are made:

- ☐ No Work Restrictions - Medically qualified to perform all necessary job functions under the indicated working conditions and environment.
- ☐ Restricted - Medically qualified to perform all necessary job functions under the indicated working conditions and environment, provided the restrictions listed below can be accommodated, and/or the recommendations listed below can be satisfied.
- ☐ Not Medically Qualified - Not medically qualified to perform all necessary job functions under the indicated working conditions and environment for which he/she has been examined. Reasons are listed below.

☐ Determination Pending (specify reason): _____

☐ Return to medical exam office for follow-up by (must be 45 days or less): _____

☐ Medical Examination Report amended (specify reason): _____
(if amended) Medical Examiner's Signature: _____ Date: _____

Additional Comments

Medical Examiner's Signature: _____

Medical Examiner's Name (Print): _____

Address: _____

Telephone Number: _____

Medcare Specialists
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