CDL-PHY
State Form # 49867
(R3/10-04)

Indiana Department of Revenue
Medical Examination Report for
Commercial Driver Fitness Determination

Commercial Driver's License, Medical Section
5252 Decatur Boulevard, Ste. R,
Indianapolis, IN 46241
Telephone: (317) 615-7335 Fax: (317) 821-2340

***Social Security Number**
This state agency is requesting disclosure of your Social Security number, under IC 4-1-8-1, in order to perform its statutory function. Disclosure is voluntary, and you will not be penalized for refusal.

1. Driver's Information — Driver completes this section

Driver's Name (Last, First, MI)	Address			
City, State, Zip Code	Age	Sex ☐M ☐F	☐ New Certification ☐ Recertification ☐ Follow Up	Work. Tel: ( ) Home Tel: ( )
Social Security No.	Birthdate (MM DD YYYY)		Date of Exam (MM DD YYYY)	
State of Issue	Driver License No.	License Type ☐ OP ☐ CH ☐ CDL OR ☐ (K) CDL	CDL Class: ☐ A ☐ B ☐ C	

2. Health History — Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes	No		Yes	No	
☐	☐	Any illness or injury in last 5 years?	☐	☐	Liver disease
☐	☐	Head/brain injuries, disorders or illnesses	☐	☐	Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin
☐	☐	Seizures, epilepsy ☐ Medication _____	☐	☐	Nervous or psychiatric disorders, e.g.; severe depression ☐ Medication _____
☐	☐	Eye disorders, or impaired vision (except corrective lenses)	☐	☐	Loss of, or altered consciousness
☐	☐	Ear disorders, loss of hearing or balance	☐	☐	Fainting, dizziness
☐	☐	Heart disease or heart attack; other cardiovascular condition ☐ Medication _____	☐	☐	Sleep disorders ☐ History of sleep apnea. Treatment _____ ☐ Pauses in breathing while asleep ☐ Daytime sleepiness including with driving ☐ Narcolepsy ☐ Loud Snoring ☐ Insomnia/deprivation of sleep
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker or IC defibrillator)	☐	☐	Stroke or paralysis
☐	☐	High blood pressure ☐ Medication _____	☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Muscular disease	☐	☐	Spinal injury or disease ☐ ☐ Chronic low back pain
☐	☐	Shortness of breath	☐	☐	Regular, frequent alcohol use
☐	☐	Lung disease, emphysema, asthma	☐	☐	Narcotic or habit forming drug use
☐	☐	Chronic bronchitis	☐	☐	Digestive problems
☐	☐	Kidney disease, dialysis			

For any YES answer, please indicate onset date, diagnosis, treating physician's name and address and any current limitations. 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 this information to be released to the Indiana Department of Revenue.

_____
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, used while driving)

Driver's Name_____ DL#_____ SS#_____

Testing (Medical Examiner completes Section 3 through 7)

3. Vision - 391.41 (b) (10)

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.

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: ☐ Corective Lenses

Monocular Visions: ☐ Yes ☐ No

Complete this section if vision testing is done by an Ophthalmologist or Optometrist.

Date of Examination _____ Telephone No. _____

Name of Ophthalmologist or Optometrist (Print) _____

Signature _____

License No./State of Issue _____

4. Hearing - 391.41 (b)(11)

Standard: **a) Must first perceive forced whispered voice ≥ 5 feet with or without hearing aid, or**
b) Average hearing loss in better ear ≤ 40dB

☐ Check if hearding aid used for tests. ☐ Check if hearing aid is **required** to meet standard.

Instructions: To convert audiometric test results from ISO to ANSI, -14dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5dB for 2,000Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

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

5. Blood Pressure/Pulse - 391.41 (b)(6)

Numerical readings must be recorded. Medical Examiner should take two readings to confirm BP

Blood Pressure	Systolic	Diastolic

Driver qualified if ≤ 140/90 .

Pulse Rate	☐ Regular ☐ Irregular

Record Pulse Rate:

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if ≤ 140/90 One-time certificate for 3 months if 140-159/90-99
160-179/100-109	Stage 2	One-time certificate for 3 months	1 year from date of exam if ≤ 140/90
≥ 180/110	Stage 3	6 monts from date of exam if ≤ 140/90	6 months if ≤140/90 ,

Medical examiner should take at least 2 readings to confirm blood pressure.

6. Laboratory & Other Test Finding

Numerical readings must be recorded.

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

Urine Specimen:	SP. GR.	Protein	Blood	Sugar

Other Testing (*Describe and record*):_____

Driver's Name_____ DL#_____ SS#_____

7. Physical Examination

Height_____(in.) Weight_____(lbs.)

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 a 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
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	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums	❑	❑
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing and swallowing.	❑	❑
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, inplantable defibrillator	❑	❑
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, cyanosis. Abnormal findings on physcial exam may require further testing such as pulmonary tests and/or xray of chest.	❑	❑
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 - 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.	❑	❑
11. Spine, other 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 and Babinski's reflexes, ataxia.	❑	❑

*Comments_____

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

- ❑ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ❑ Meets standards, but periodic evaluation required.
  Due to _____driver qualified only for:
  ❑ 3 months ❑ 6 months ❑ 1 year ❑ Other
- ❑ Qualified by operation of 49 CFR 391.64 (See page 3 of instructions)
- ❑ Does not meet standards
- ❑ Wearing corrective lenses
- ❑ Wearing hearing aid
- ❑ Driving within an exempt intracity zone (see 49 CFR 391-62)
- ❑ Skills Performance Evaluation (SPE) Certificate (See page 3 of instructions)
- ❑ Accompanied by a_____ waiver/exemption
  Driver must present exemption at time of certification.
- ❑ Temporarily disqualified due to (condition or medication) _____
  Return to Medical Examiner's office for follow up on _____

Medical Examiner's Name (Print)_____ Medical Examiner's Signature_____

Telephone Number_____ Address_____

If meets DOT standards, complete the DOT Medical Examiner's certificate according to 49 CFR 391.43 (h).

Driver's Name_____ DL#_____ SS#_____

Notice for all CMV drivers: Drivers must carry one of the Medical Examiner's Certificate when operating a commercial vehicle.

To the Medical Examiner: Complete only one of these Medical Examiner Certifications.

DOT Medical Examiner's Certificate to be completed if the driver meets Federal Motor Carrier Safety Regulations 49 CFR 391.41-391.49

DOT Interstate Medical Examiner's Certificate

I certify that I have examined _____ in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and if applicable, only when:

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____ waiver/exemption
- ☐ Driving within an exempt intracity zone (49 CFR 391.62)
- ☐ Accompnaied by a Skill performance Evaluation Cert. (SPE)
- ☐ Qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

Medical Certificate Expiration Date (Not the Medical Examiner's state license certificate expiration date)	MM	DD	YYYY
[redacted]			

Signature of Medical Examiner	Date	Telephone

Medical Examiner's Name (please print)	☐ MD ☐ DO ☐ Chiropractor ☐ Physician Assistant ☐ Advanced Practice Nurse

Medical Examiner's:	Issuing State	License or Certificate No.
[redacted]		

Signature of Driver	Driver's License No.	State

Address of Driver

DOT (Interstate)
OP (Operator's)
CH (Chauffeur's)
CDL (Commercial Driver's License Interstate)

This card to be issued to a CDL-K Intrastate license holder only.

Indiana CDL Intrastate Medical Examiner's Certification

I certify that I have examined _____, in my medical opinion this examinee did not have at the time of this examination any medical disorder or physical condition which was likely to interfere with his/her ability to safely operate a commercial motor vehicle or a motor vehicle used to convey public passengers. The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

Medical Certificate Expiration Date (Not the Medical Examiner's state license certificate expiration date)	MM	DD	YYYY
[redacted]			

Signature of Medical Examiner	Date	Telephone

Medical Examiner's Name (please print)	☐ MD ☐ DO ☐ Chiropractor ☐ Physician Assistant ☐ Advanced Practice Nurse

Medical Examiner's:	Issuing State	License or Certificate No.
[redacted]		

Signature of Driver	Driver's License No.	State

Address of Driver

Indiana (Intrastate)
(K) CDL (Commercial Driver's License Intrastate)

Please make two copies. Send one copy to the Department and keep a copy for your records. Medical Examiner's Certificate must accompany the Medical Examination Report (Medical Long Form) when filing with the Indiana Department of Revenue, Motor Carrier Services, CDL Section.