FAST Lane

After Hours Urgent Care by Lane Regional Medical Center

February of 2024 the Federal Motor Carrier Safety Administration (FMCSA) updated their policy for applicants on prescription medication.

What does this mean? A form needs to be filled out by the prescribing provider in order for us to complete the DOT Medical Physical.

Attached are 3 different forms:

1. ANY and ALL prescription medications. (Blood Pressure, Cholesterol, Inhalers, Anxiety, etc…)
2. Insulin medications.
3. Non-Insulin medications.

Only the form(s) that pertain to the patient needs to be filled out!

(Ex: if they are not on insulin or non-insulin medication--- DO NOT fill those forms out)

We complete the physical once those completed forms are returned to us. Any questions please call 225-570-2618.

Please note, the expiration date on this form relates to the process for renewing the Information Collection Request that includes this form with the Office of Management and Budget. This requirement to collect information as requested on this form does not expire.

391.41 CMV DRIVER MEDICATION FORM

Responsibilities, work schedules, physical and emotional demands, and lifestyles among commercial drivers vary by the type of driving that they do. Some of the main types of drivers include the following: turn around or short relay (drivers return to their home base each evening); long relay (drivers drive 9-11 hours and then have at least a 10-hour off-duty period), straight through haul (cross country drivers); and team drivers (drivers share the driving by alternating their 5-hour driving periods and 5-hour rest periods.) The following factors may be involved in a driver's performance of duties: abrupt schedule changes and rotating work schedules, which may result in irregular sleep patterns and a driver beginning a trip in a fatigued condition; long hours; extended time away from family and friends, which may result in lack of social support; tight pickup and delivery schedules, with irregularity in work, rest, and eating patterns, adverse road, weather and traffic conditions, which may cause delays and lead to hurriedly loading or unloading cargo in order to compensate for the lost time; and environmental conditions such as excessive vibration, noise, and extremes in temperature. Transporting passengers or hazardous materials may add to the demands on the commercial driver. There may be duties in addition to the driving task for which a driver is responsible and needs to be fit. Some of these responsibilities are: coupling and uncoupling trailer(s) from the tractor, loading and unloading trailer(s) (sometimes a driver may lift a heavy load or unload as much as 50,000 lbs. of freight after sitting for a long period of time without any stretching period); inspecting the operating condition of tractor and/or trailer(s) before, during and after delivery of cargo; lifting, installing, and removing heavy tire chains; and, lifting heavy tarpaulins to cover open top trailers. The above tasks demand agility, the ability to bend and stoop, the ability to maintain a crouching position to inspect the underside of the vehicle, frequent entering and exiting of the cab, and the ability to climb ladders on the tractor and/or trailer(s). In addition, a driver must have the perceptual skills to monitor a sometimes complex driving situation, the judgment skills to make quick decisions, when necessary, and the manipulative skills to control an oversize steering wheel, shift gears using a manual transmission, and maneuver a vehicle in crowded areas.

CERTIFIED MEDICAL EXAMINER'S REQUEST FOR INFORMATION

Driver Name: _____ **Date of Birth:** _____

The above patient/driver is being evaluated to determine whether he/she meets the medical standards of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle (CMV) in interstate commerce. During the medical evaluation, it was determined this individual is taking medication(s) that may impair his/her ability to safely operate a CMV. As the certified Medical Examiner (ME), I request that you review the regulations as noted below, complete this form, and return it to me at the mailing address, email address, or fax number specified below. The final determination as to whether the individual listed in this form is physically qualified to drive a CMV will be made by the certified ME.

49 CFR 391.41(b), **Physical Qualifications for Drivers: A person is physically qualified to drive a CMV if that person … (12)(i) Does not use any drug or substance identified in 21 CFR 1308.11 Schedule I, an amphetamine, a narcotic, or other habit-forming drug. (ii) Does not use any non-Schedule I drug or substance that is identified in the other Schedules in 21 part 1308 except when the use is prescribed by a licensed medical practitioner, as defined in § 382.107, who is familiar with the driver's medical history and has advised the driver that the substance will not adversely affect the driver's ability to safely operate a CMV.**

Printed Name of Certified Medical Examiner: _____ Date: _____

Street Address: 19900 Old Scenic Hwy Suite H City, State, Zip Code: Zachary, LA 70791

Email Address: fastlaneww@lanermc.org Fax Number: (225) 570-8539

Signature of Certified Medical Examiner: _____

Use of this form by the certified medical examiner is voluntary.

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

PRESCRIBING HEALTHCARE PROVIDER DATA

1. List all medications and dosages that you have prescribed to the above named individual.

2. List any other medications and dosages that you are aware have been prescribed to the above named individual by another treating health care provider.

3. What medical conditions are being treated with these medications?

4. It is my medical opinion that, considering the mental and physical requirements of operating a CMV and with awareness of a CMV driver's role (consistent with "The Driver's Role" statement on page 1), my patient:

(a) has no medication side effects from medication(s) that I prescribe that would adversely affect the ability to safely operate a CMV; and

(b) has no medical condition(s) that I am treating with the above medication(s) that would adversely affect the ability to safely operate a CMV.

○ Yes ○ No

Printed Name of Prescribing Healthcare Provider: _____ State of Licensure: _____

Street Address: _____ City, State, Zip Code: _____

Email Address: _____ Fax Number: _____ Date: _____

Signature of Prescribing Healthcare Provider: _____

Use of this form by the certified medical examiner is voluntary.

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MCSA-5870

OMB No.: 2126-0006
Expiration Date: 03/31/2025

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

Individual's Name: _____

INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

Name: _____ **DOB:** _____

Driver's License Number *(if applicable)*: _____ **State:** _____

This individual is being evaluated either to determine whether he/she meets the physical qualification standards of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle or because the individual has recently experienced a severe hypoglycemic episode. A treating clinician should complete this form to the best of his/her ability based on his/her knowledge of the individual's medical history. Completion of this form does not imply that a treating clinician is making a medical certification decision to qualify the individual to drive a commercial motor vehicle. Any determination as to whether the individual is physically qualified to drive a commercial motor vehicle will be made by a certified medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines a treating clinician as a healthcare professional who manages, and prescribes insulin for, treatment of the individual's diabetes mellitus as authorized by the healthcare professional's applicable State licensing authority.

Instructions to the Individual:

When you are being evaluated prior to a medical certification examination, the certified medical examiner must receive this form and begin the examination no later than 45 calendar days after a treating clinician signs this form.

When you are being evaluated after a severe hypoglycemic episode, you must retain this form and give it to the certified medical examiner at your next medical certification examination.

Insulin-Treated Diabetes Mellitus Diagnosis

1. Date insulin use began: _____

Blood Glucose Self-Monitoring Records

2. Has the individual maintained at least the preceding 3 months of ongoing blood glucose self-monitoring records while being treated with insulin that are measured with an electronic glucometer that stores all readings, records the date and time of readings, and from which data can be electronically downloaded?

   ☐ Yes ☐ No

3. Has the individual provided at least the preceding 3 months of electronic self-monitoring records while being treated with insulin from his/her glucometer to the treating clinician for review?

   ☐ Yes ☐ No

If no, provide details:

_____

Note: *The individual is not physically qualified to operate a commercial motor vehicle for up to the maximum 12-month period until he/she provides a treating clinician with at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with insulin. At the certified medical examiner's discretion, the individual who does not possess at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with insulin may qualify to operate a commercial motor vehicle for up to but not more than 3 months.*

4. How many times per day is the individual testing his/her blood glucose? _____

5. Is the individual compliant with blood glucose self-monitoring based on his/her specific treatment plan?

☐ Yes ☐ No

Comments, if necessary:

_____

Severe Hypoglycemic Episodes

6. Has the individual experienced any severe hypoglycemic episodes within the preceding 3 months? *FMCSA defines a severe hypoglycemic episode as one that requires the assistance of others, or results in loss of consciousness, seizure, or coma.*

☐ Yes ☐ No

If yes, provide date(s) of occurrence, whether the cause has been addressed, and associated details (attach additional pages as needed):

_____ ATTACH FILE

_____

Hemoglobin A1C (HbA1C) Measurements

7. Has the individual had HbA1C measured intermittently over the last 12 months, with the most recent measure within the preceding 3 months?

☐ Yes ☐ No

If yes, attach the most recent result. ATTACH FILE

Diabetes Complications

8. Does the individual have signs of diabetic complications or target organ damage? *This information will be used by the certified medical examiner in determining whether the listed conditions would impair the individual's ability to safely operate a commercial motor vehicle.*

a. Renal disease/renal insufficiency (e.g., diabetic nephropathy, proteinuria, nephrotic syndrome)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

b. Diabetic cardiovascular disease (e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

c. Neurological disease/autonomic neuropathy (e.g., cardiovascular, gastrointestinal, genitourinary)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

d. Peripheral neuropathy (e.g., sensory loss, decreased sensation, loss of vibratory sense, loss of position sense)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, location, type of involvement, current treatment, and whether the condition is stable:

_____

_____

e. Lower limb (e.g., foot ulcers, amputated toes/foot, infection, gangrene)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

f. Other? *(specify condition)*: _____

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

Progressive Eye Diseases

9. Date of last comprehensive eye examination: _____

10. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?

☐ Yes ☐ No

If yes, provide date of diagnosis: _____

Individual's Name: _____

11. Has the individual been diagnosed with any other progressive eye disease(s) (e.g., macular edema, cataracts, glaucoma)?

☐ Yes ☐ No

If yes, specify the disease(s), provide the dates of diagnoses, current treatment, and whether the condition is stable:

_____

_____

12. Additional Comments *(attach additional pages as needed)*

_____

_____

_____

_____

ATTACH FILE

I attest that I am a treating clinician (as defined above), that this individual maintains a stable insulin regimen and proper control of his/her insulin-treated diabetes mellitus, and that the information provided is true and correct to the best of my knowledge.

_____
Date

_____ _____
Printed Name and Medical Credential *Signature*

_____
Professional License Number and State

_____ _____
Phone Number *Email*

_____ _____
Street Address *City, State, Zip Code*

MCSA-5872

OMB No.: 2126-0081
Expiration Date: 01/31/2027

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

NON-INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

Driver Name: _____ **DOB:** _____

The individual named above is being evaluated to determine whether the individual meets the physical qualification standards of the Federal Motor Carrier Safety Administration to operate a commercial motor vehicle in interstate commerce. During the medical evaluation, it was determined this individual has a diagnosis of non-insulin-treated diabetes mellitus. Although there is not a standard specific to non-insulin-treated diabetes mellitus, this information will be used by the certifying medical examiner to evaluate any diabetes-related complications and/or target organ damage and to determine whether the individual's physical condition is adequate to enable the individual to operate a commercial motor vehicle safely. The final determination as to whether the individual listed in this form is physically qualified to drive a commercial motor vehicle will be made by the certifying medical examiner.

As the certifying medical examiner, I request that you review and complete this form, and return it to me via the individual, or at the mailing address, email address, or fax number specified below.

_____	_____
Printed Name of Certified Medical Examiner	*Signature of Certified Medical Examiner*
_____	_____
Date	*Email*
_____	_____
Phone Number	*Fax Number*
_____	_____
Street Address	*City, State, Zip Code*

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Driver Name: _____

Non-Insulin-Treated Diabetes Mellitus Diagnosis

1. Date of diabetes mellitus diagnosis: _____
2. Medications - List all diabetes-related medications, dosage, and date treatment initiated *(attach additional pages if necessary)*

   Medication: _____ Dosage: _____ Date started: _____

   Medication: _____ Dosage: _____ Date started: _____

   Medication: _____ Dosage: _____ Date started: _____

ATTACH FILE

Blood Glucose Self-Monitoring

3. How many times per day is the individual testing blood glucose levels? _____
4. Is the individual compliant with glucose monitoring based on the individualized diabetes treatment plan?

   ☐ Yes ☐ No

Diabetes Management and Control

5. Has the individual been on a stable individualized diabetes treatment plan with good glucose control?

   ☐ Yes ☐ No

   If no, explain why not *(attach additional pages if necessary)*:

   _____

   _____

ATTACH FILE

6. Has the individual experienced any recent severe hypoglycemic episodes *(e.g., episodes requiring the assistance of others or resulting in loss of consciousness, seizure, or coma)*?

   ☐ Yes ☐ No

   If yes, provide date(s) of occurrence and associated details *(attach additional pages if necessary)*:

   _____

   _____

ATTACH FILE

7. Has the individual experienced any recent significant hyperglycemic episodes *(e.g., diabetic ketoacidosis and diabetic hyperglycemic hyperosmolar syndrome)*?

   ☐ Yes ☐ No

   If yes, provide date(s) of occurrence and associated details *(attach additional pages if necessary)*:

   _____

   _____

ATTACH FILE

Driver Name: _____

Hemoglobin A1c (HbA1c) Measurements

8. Has the individual had HbA1c measured intermittently over the last 12 months?

☐ Yes ☐ No

If yes, attach the most recent result. ATTACH FILE

Diabetes Complications

9. Does the individual have signs of diabetes complications or target organ damage?

a. Renal disease/renal insufficiency *(e.g., diabetic nephropathy, proteinuria, nephrotic syndrome)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

b. Cardiovascular disease *(e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

c. Neurological disease/autonomic neuropathy *(e.g., cardiovascular, gastrointestinal, genitourinary)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

d. Peripheral neuropathy *(e.g., sensory loss, decreased sensation, loss of vibratory sense, loss of position sense)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

e. Lower limb *(e.g., foot ulcers, amputated toes/foot, infection, gangrene)*?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

f. Other?

☐ Yes ☐ No

If yes, provide the condition, date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

Diabetic Retinopathy

10. Date of last eye examination: _____

11. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?

☐ Yes ☐ No

If yes, provide date of diagnosis: _____

Comments *(if necessary)*:

_____

_____

_____

_____

I am the treating healthcare provider for the above individual.

☐ Yes ☐ No

***Comments** (if necessary):*

_____

_____

_____

Printed Name of Treating Healthcare Provider	*Signature of Treating Healthcare Provider*
Professional License Number and State	*Date*
Phone Number	*Email*
Street Address	*City, State, Zip Code*