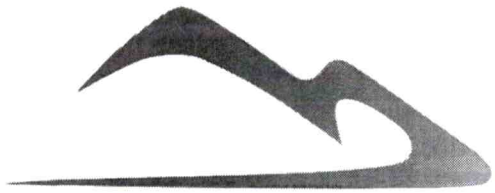

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PATIENT NAME_____ **DATE** _____

PATIENT ADDRESS_____ **CITY**_____ **ZIP CODE**_____

DOB_____ **PHONE**_____

EMPLOYER NAME_____

MEDICAL SURVEILLANCE

19A PHYSICAL
DOT PHYSICAL
FIRE DEPT PHYSICAL
PHYSICAL
POLICE/ROAD PATROL PHYSICAL
MASK FIT/CLEARANCE
RESPIRATOR WRITTEN OPINION
SCBA FIT TEST
AUDIOGRAM
PFT
EKG
VISUAL ACUITY
PULSE OXIMETRY
ASBESTOS
HAZMAT

TESTING

BLOOD COLLECTION
HAIR/FINGERNAIL
BREATH ETOH
DOT/NIDA COLLECT & TEST
SAP5 COLLECT & TEST
SAP 10 COLLECT & TEST

IMMUNIZATIONS

TETANUS
PPD
HEP B #_____
HEP A
MMR
FLU/PNEUMONIA

LABORATORY

CBC
CHOLESTEROL
HEPATITIS SCREEN
HIV SCREEN
LIPID PANEL
MMR TITER
GLUCOMETER FINGER STICK
HEP B TITER
ZPP
SERUM LEAD
CHEST X RAY 1 VIEW/2 VIEW
URINALYSIS
PSA
OTHER _____

WORKERS COMPENSATION

NEW PATIENT

99201 E/M LEVEL 1
99202 E/M LEVEL 2
99203 E/M LEVEL 3
99204 E/M LEVEL 4
99205 E/M LEVEL5

ESTABLISHED PATIENT

99211 E/M LEVEL 1
99212 E/M LEVEL 2
99213 E/M LEVEL 3
99214 E/M LEVEL 4
99215 E/M LEVEL 5

DIAGNOSIS

INTERNAL NOTES:_____

_____

_____

_____

_____

_____

_____

SIGNATURE – MEDICAL PROVIDER

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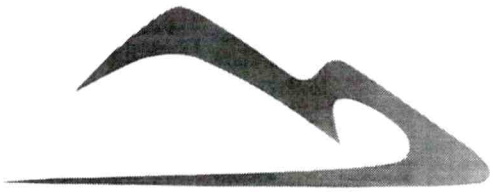
WWW.EASTERNMED.COM



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CONSENT FOR TREATMENT & RELEASE OF INFORMATION

I consent to receiving treatment and/or a physical examination to be performed by the physician, nurse practitioner and/or professional staff at the Occupational Health Center. I permit the physician, nurse practitioner, and or staff of Eastern Med, LLC to treat me in ways they judge beneficial to me or have been requested by my employer or prospective employer. I understand that this care may include tests, physical examinations, immunizations and the drawing of my blood.

I further consent that the medical information and results of such test or treatment that is related to my job / job functions may be released to the guarantor (Example: The company authorizing and paying for the medical services or their agents).

PERMISSION TO CONTACT YOUR MEDICAL PROVIDER(S)
&
PRIVACY STATEMENT / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

During the completion of your medical exam, significant findings may be identified which could have an impact on the performance of your work related duties. Further information from your medical provider(s) may be necessary to clear you for the employment or volunteer position you currently seek.

Please sign below if you agree to allow us to contact your medical provider(s) regarding significant medical findings, and / or additional information to clear you for your duties.

Furthermore, you also acknowledge that you have read and understand Eastern Med's HIPAA policy regarding the use of disclosure of protected health information, which is made in accordance with Federal Law (electronic version is available at www.easternmed.com/resources.php).

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

The patient is unable to give consent because: _____

Signature: _____ Date: _____

Relationship: _____

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NEW YORK STATE OF OPPORTUNITY | Department of Motor Vehicles

MEDICAL EXAMINATION REPORT OF DRIVER UNDER ARTICLE 19-A

dmv.ny.gov

INSTRUCTIONS TO MEDICAL EXAMINER: The complete standards and instructions for conducting this examination are found in Section 6.10 of the Commissioner's Regulations, 15NYCRR6, and can be found at dmv.ny.gov/art19. They are also available from the driver's carrier named below or from the Bus Driver Unit. **For New/Initial Examinations and Recertification**–review/complete **ALL** items on the form and sign where indicated on last page. **For Follow-up Examinations**–complete **ONLY** those items which require follow-up information and/or evaluation from a prior examination. Sign the form where indicated. If additional space is required for further comments and information, use form DS-874C, and attach it to this form.

1 DRIVER/CARRIER INFORMATION *(to be completed by the driver and/or driver's carrier)*

Driver's Last Name	First	M.I.	Date of Birth (Month/Day/Year)	Age	Sex ☐ Male ☐ Female

Street Address	City	State	Zip Code

License ID Number (from Driver License)	State	Class of Driver's License	Endorsements	Restrictions	Expiration Date

Carrier/DBA Name	Legal Name (if different)	19-A Business ID Number

2 HEALTH HISTORY *(to be completed by the driver and reviewed by the medical examiner)*

Yes	No	
☐	☐	Any illness or injury in the last 5 years?
☐	☐	Head/Brain injuries, disorders or illnesses
☐	☐	Seizures, epilepsy
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack; other cardiovascular condition
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
☐	☐	High blood pressure
☐	☐	Muscular disease
☐	☐	Shortness of breath
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar controlled by *(check all that apply)*: ☐ diet ☐ insulin ☐ other medication
☐	☐	Incident of hyperglycemic or hypoglycemic shock
☐	☐	Loss of, or altered consciousness
☐	☐	Fainting, dizziness
☐	☐	Nervous or psychiatric disorders, e.g., severe depression
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, obstructive sleep apnea, loud snoring
☐	☐	Stroke or paralysis
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain
☐	☐	Regular, frequent alcohol use
☐	☐	Narcotic or habit forming drug use
☐	☐	Tuberculosis
☐	☐	Other _____

For any YES answer, the driver should indicate the condition, onset date, diagnosis, treating medical examiner's name and address, and any current conditions or comments here: _____

List all medications (including over-the-counter medications) used regularly or recently. _____

☐ ***Additional comments/medications on attached DS-874C***

I certify that the above information and any other information on any accompanying DS-874C, if used, is complete and true. I understand that inaccurate, false or missing information may invalidate this examination.

X _____ _____

(Driver's Signature) (Date)

Medical Examiner's Comments: _____

TESTING (SECTIONS 3 THROUGH 8 TO BE COMPLETED BY THE MEDICAL EXAMINER)

3 VISION

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	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..... ☐ Yes ☐ No

Does applicant have monocular vision?..... ☐ Yes ☐ No

Complete next two lines only if vision testing is done by an ophthalmologist or optometrist.

Date of Examination | Name of Ophthalmologist or Optometrist (print) | Telephone Number

License Number/State of Issue | X (Signature of Examiner)

4 BLOOD PRESSURE/PULSE RATE

Standard: If the blood pressure is consistently above 160/90 mm. Hg., further testing may be necessary to determine whether the driver is qualified to operate a bus. Numerical reading must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure Readings	1) Systolic/Diastolic	2) Systolic/Diastolic

Pulse Rate: ☐ Regular ☐ Irregular **Record Pulse Rate:** _____

Date of Examination

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Driver's Name: Last _____ First _____ MI _____ Driver's License ID # _____

5 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

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

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

Right ear \Feet	Left ear \Feet

OR

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

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

6 LABORATORY AND OTHER TEST FINDINGS -

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. Other Testing (Describe and record):

URINE SPECIMEN

SP. GR	PROTEIN	BLOOD	SUGAR

7 PHYSICAL EXAMINATION *(to be completed by the medical examiner)* - **Height** _____ **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 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.

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 or swallowing.	☐	☐
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable 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 physical 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.	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; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski reflexes, ataxia.	☐	☐

*** MEDICAL EXAMINER'S COMMENTS:** _____

☐ ***Additional comments on attached DS-874C.***

8 MEDICAL EXAMINER'S CERTIFICATION: ☐ **New/Initial Certification** ☐ **Recertification** ☐ **Follow-Up**

I certify that I have examined (*Print Driver's Full Name*) _____ in accordance with the Commissioner's Regulations and with knowledge of the driver's duties. In accordance with Commissioner's Regulation 6.10, I find:

☐ the person named above is physically or medically qualified.

☐ the person named above **IS NOT** physically or medically qualified because _____

☐ the person named above is physically or medically qualified with **Restrictions and/or Follow-up** as detailed below:

- ☐ Qualified only when wearing corrective/contact lenses.
- ☐ Qualified - Certification required every six months for **diabetic condition**.
- ☐ Qualified only when wearing a hearing aid.
- ☐ Qualified only by use of prosthetic devices or equipment modifications. Description/Type: _____
- ☐ Qualified, other: _____

REMARKS: _____ ☐ ***Additional comments on attached DS-874C.***

Print name and check title of: _____ Date: _____

☐ Examining Physician
☐ Nurse Practitioner
☐ Physician Assistant
☐ Advanced Practice Nurse*
(who is not a Nurse Practitioner)

Signature of Examiner: X _____

Address of Examiner: _____

License or Certificate No./Issuing State _____

* If the examination is conducted by an Advanced Practice Nurse, who is not a Nurse Practitioner, the Supervising Physician must certify as follows:
I certify that the individual who conducted the above examination was acting under my direction and supervision and, if applicable, in accordance with a written practice or protocol agreement.

Print _____ X _____ _____

(Name of Supervising Physician) (Signature of Supervising Physician) License or Certificate No./Issuing State

THE CARRIER MUST KEEP THE ORIGINAL EXAMINATION REPORT (NOT A PHOTOCOPY) IN THE EMPLOYEE'S 19-A FILE ANY PHOTOCOPIES MUST IDENTIFY THE LOCATION OF THE ORIGINAL

New York State Department of Motor Vehicles

DS-874C (4/10)

SUPPLEMENT TO: Medical Examination of Driver Report Under Article 19-A

Driver Last Name	Driver First Name	M.I.	Client ID #	Date

This form is to be used **ONLY** as a supplement to the Medical Examination form (DS-874), and should be attached to that form when completed. This form (DS-874C) is ***not required*** to be used, but if additional space is needed by the examining medical staff or the driver being examined, this is the proper form to be used.

Continued from item 2 on form DS-874

HEALTH HISTORY (additional driver and/or medical examiner comments and information)

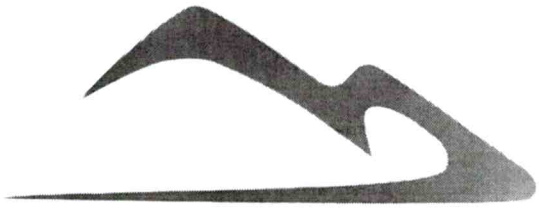
Continued from item 7 on form DS-874

PHYSICAL EXAMINATION (additional comments)

Continued from item 8 on form DS-874

MEDICAL EXAMINER'S CERTIFICATION & REMARKS (additional remarks)

When used, this form MUST BE ATTACHED to the completed form DS-874, Medical Examination Report of Driver Under Article 19-A. This form, by itself is NOT a valid Medical Report.



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SLEEP DISORDER INSTRUCTIONS

Sleep Disorders can present a major problem for driving safely. There is a four-fold chance of a motor vehicle accident in people who have sleep disorders. Lack of proper amount of sleep can lead to difficulty with response time and alertness and can lead to falling asleep while driving.

- If you have difficulty with drowsiness during your work hours, it is extremely important that you not attempt to drive.
- If your drowsiness is due to several days of loss of sleep secondary to an illness, injury, or mental stress. We strongly recommend that you see your primary doctor and avoid driving until a healthy sleep pattern has returned.
- If you are having symptoms of work time drowsiness for unknown reasons, we strongly recommend that you remove yourself from driving. You should discuss these symptoms with your primary care physician and have a sleep evaluation performed.
- If you are receiving treatment for a sleep disorder such as obstructive sleep apnea, you must follow the prescribed treatments. If you are on CPAP for sleep apnea, you will need yearly examinations by the sleep specialist to give clearance for recertification for state or federal controlled commercial licenses. If you skip a night using the CPAP, you are at risk of having an episode of sleep during work. You must remove yourself from driving until the day after using the CPAP. The CPAP machines have memory chips in them, which identify what nights they have been used. Evaluations of the memory chips on a random basis will be part of the yearly evaluations.

I, the undersigned, have read and understand the importance of following the instructions indicated above.

_____ _____

Signature Date

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