



EASTERNMED

Your Health And Safety Source

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 LEVEL 5

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

EASTERN MED, LLC
5010 STATE HWY 30, STE 101
AMSTERDAM, NY 12010
Ph: (518) 843-6860
Fax: (518) 684-0156
WWW.EASTERNMED.COM



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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Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)**PERSONAL INFORMATION**

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____ Age: _____
Street Address: _____ City: _____ State/Province: _____ Zip Code: _____
Driver's License Number: _____ Issuing State/Province: _____ Phone: _____ Gender: ☐ M ☐ F
E-mail (optional): _____ CLP/CDL Applicant/Holder*: ☐ Yes ☐ No
Driver ID Verified By**: _____
Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ☐ Yes ☐ No ☐ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below.

☐ Yes ☐ No ☐ Not SureAre you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)?
If "yes," please describe below.☐ Yes ☐ No ☐ Not Sure

(Attach additional sheets if necessary)

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.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY (continued)

Do you have or have you ever had:	Not				Not		
	Yes	No	Sure		Yes	No	Sure
1. Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insulin used	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other health condition(s) not described above: ☐ Yes ☐ No ☐ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ☐ Yes ☐ No ☐ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report (to be filled out by the medical examiner)

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse rate: _____ Pulse rhythm regular: ☐ Yes ☐ No

Height: _____ feet _____ inches Weight: _____ pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting			Urinalysis is required. Numerical readings must be recorded.				
Second reading (optional)							
Other testing if indicated			Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.				

Vision

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

Acuity

	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/ _____	20/ _____	Right Eye: _____ degrees
Left Eye:	20/ _____	20/ _____	Left Eye: _____ degrees
Both Eyes:	20/ _____	20/ _____	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors

Monocular vision

Referred to ophthalmologist or optometrist?

Received documentation from ophthalmologist or optometrist?

Yes No OR

☐ ☐ ☐

☐ ☐ ☐

☐ ☐ ☐

☐ ☐ ☐

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results

Right Ear Left Ear

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

Audiometric Test Results

Right Ear

Left Ear

500 Hz 1000 Hz 2000 Hz 500 Hz 1000 Hz 2000 Hz

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

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 neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	<input type="radio"/>	<input type="radio"/>	8. Abdomen	<input type="radio"/>	<input type="radio"/>
2. Skin	<input type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input type="radio"/>	<input type="radio"/>
3. Eyes	<input type="radio"/>	<input type="radio"/>	10. Back/Spine	<input type="radio"/>	<input type="radio"/>
4. Ears	<input type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input type="radio"/>	<input type="radio"/>	13. Gait	<input type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input type="radio"/>	<input type="radio"/>	14. Vascular system	<input type="radio"/>	<input type="radio"/>

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:**MEDICAL EXAMINER DETERMINATION (Federal)**

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- ☐ Does not meet standards (specify reason): _____
- ☐ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ☐ Meets standards, but periodic monitoring required (specify reason): _____
- Driver qualified for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ other (specify): _____
- ☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption (specify type): _____
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)
- ☐ Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- ☐ Determination pending (specify reason): _____
- ☐ Return to medical exam office for follow-up on (must be 45 days or less): _____
- ☐ Medical Examination Report amended (specify reason): _____
- (if amended) Medical Examiner's Signature: _____ Date: _____
- ☐ Incomplete examination (specify reason): _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

- ☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse
- ☐ Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):

☐ Does not meet standards in 49 CFR 391.41 with any applicable State variances (specify reason): _____

☐ Meets standards in 49 CFR 391.41 with any applicable State variances

☐ Meets standards, but periodic monitoring required (specify reason): _____

Driver qualified for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ other (specify): _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption (specify type): _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements (State) _____

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

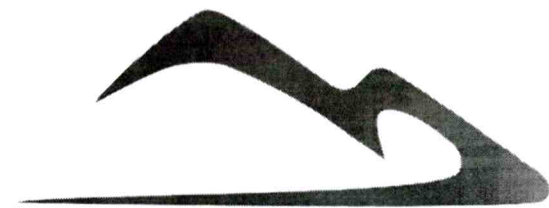
Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____



EASTERNMED

Your Health And Safety Source

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.

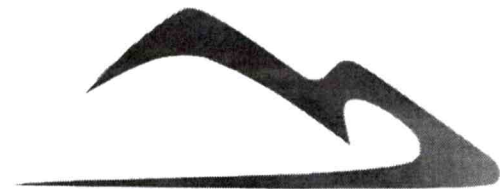
- If you have difficulty with drowsiness during your work hours, it is extremely important that you not attempt to drive.
- If your drowsiness is due to several days of loss of sleep secondary to an illness, injury, or mental stress. We strongly recommend that you see your primary doctor and avoid driving 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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Authorization for Release of Confidential Medical Information

Patient Name: _____

Date: _____

Address: _____

Phone: _____ Date of Birth: _____

I, the undersigned, hereby authorize and request _____ to release all confidential medical information regarding my condition for the period of the time specified below. This authorization includes physical forms, progress notes, consultation, laboratory tests, x-ray reports, diagnostic studies, telephone messages, medication and health flow maintenance flow sheets, immunization records, and discharge summaries.

Disclosure information to:

Employer / Facility / Physician Name

Address / Phone number

Reason for this release of information

Nature of condition (be as specific as possible)

Date of Service: From: _____ To: _____

I understand that I can decide to at any time to cancel this release in writing but, that letter will not apply to records already sent.

Time during which release is authorized (*Please check one*):



1 year

or



From: _____ To: _____

Signature

Date

Relationship if other than patient

Information release from Eastern Med

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