<u>Diabetes Treatment Information for DOT Medical Certificate</u>

Patient Name: ____________________________ **Date**: ________________________

Patients date of birth: ________________________

Please indicate the name and address of the overseeing physician treating the aforementioned patient for diabetes:

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When was your patient's diabetes diagnosed? ____

- Please indicate the date and result of the patients last hemoglobin A1C test:

  ____

- List the medications being used to treat the patients diabetes:

  ____

  ____

- Does the patient exhibit any side effects of the above-mentioned medications that would interfere with his/her ability to drive a commercial motor vehicle ? *Please indicate in the space below **(YES/NO)***. If yes, please explain:

  ____

  ____

- Does the patient have any complications from diabetes? (*ie. Kidney disease, cardiovascular, neurologic, retinopathy*). *Please indicate in the space below **(YES/NO)***. If yes, please explain:

  ____

- When was your patient's last dilated eye exam?____

- Has the patient had a severe hypoglycemic or hyperglycemic reaction in the last 12 months that caused a seizure, loss of consciousness, or has required assistance from another individual or hospitalization? *Please indicate in the space below **(YES/NO)***. If yes, please explain (with date of occurrence):

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- Do you feel that your patient can safely drive a commercial motor vehicle ? *Please indicate in the space below **(YES/NO)***. If No, please explain:

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____________________________________ ____________________________________

Physician Name **License #**