

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

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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)*:

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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. 

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:

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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