FAMILY CONVENIENCE CLINIC

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OBSTRUCTIVE SLEEP APNEA DOT CLEARANCE FORM

Please use this form to provide additional information related to the medical condition defined below. This information is necessary for our assessment of a driver's ability to safely operate a commercial motor vehicle

Patient Information: (Please Print)

Last Name: First: Middle:

Date of Birth: / / Date of Exam: / /

Supplemental Medical Information:

Please provide the following information so the medical examiner may complete the DOT medical examination. By signing below, you are only attesting to the patient's defined medical condition.

1. Does the patient have a current diagnosis of obstructive sleep apnea? Check one: ☐ YES ☐ NO
2. Results of Sleep Study: _____ Date: ____/ /____
3. Treatment (If Necessary): _____
4. Is the patient compliant with the prescribed treatment? Check one: ☐ YES ☐ NO
5. Does the patient currently experience daytime drowsiness or other symptoms that might interfere with safe driving? Check one: ☐ YES ☐ NO
   If yes, please explain: _____
6. Has the patient been scheduled for a regular follow-up evaluation? Check one: ☐ YES ☐ NO

Additional Notes: _____

Treating Medical Provider Recommendation

Treating Medical Provider:

Given your knowledge of the patient's medical condition, do you feel they can safely operate a commercial motor vehicle? Check one: ☐ YES ☐ NO

Provider: _____ Signature: _____ Date: _____

Thank you for providing the requested information. Please fax the completed form to our office.

FOR FCC STAFF USE ONLY:

Provider: _____ Signature: _____ Date: _____