U.S. Department of Transportation
Federal Motor Carrier Safety Administration
Individual's Name:

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	INSULIN-TREATED DIABETES MELLITUS ASSESSM	ENI FORM
Na	Name:	DOB:
Dr	Driver's License Number (if applicable):	State:
Fedhasiabid	This individual is being evaluated either to determine whether he/she meets the ph Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial mot has recently experienced a severe hypoglycemic episode. A treating clinician should co ability based on his/her knowledge of the individual's medical history. Completion of the clinician is making a medical certification decision to qualify the individual to drive determination as to whether the individual is physically qualified to drive a commerce certified medical examiner on FMCSA's National Registry of Certified Medical Examples.	tor vehicle or because the individual implete this form to the best of his/he his form does not imply that a treating the a commercial motor vehicle. Any cial motor vehicle will be made by a
	FMCSA defines a treating clinician as a healthcare professional who manages, and pathe individual's diabetes mellitus as authorized by the healthcare professional's applications.	
Ins	Instructions to the Individual:	
	When you are being evaluated prior to a medical certification examination, the certified form and begin the examination no later than 45 calendar days after a treating clinician	
	When you are being evaluated after a severe hypoglycemic episode, you must retain medical examiner at your next medical certification examination.	this form and give it to the certified
Ins	Insulin-Treated Diabetes Mellitus Diagnosis	
1.	1. Date insulin use began:	
Ble	Blood Glucose Self-Monitoring Records	
2.	2. Has the individual maintained at least the preceding 3 months of ongoing blood gl being treated with insulin that are measured with an electronic glucometer that sto time of readings, and from which data can be electronically downloaded?No	
3.	3. Has the individual provided at least the preceding 3 months of electronic self-mon with insulin from his/her glucometer to the treating clinician for review?	itoring records while being treated

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

Fed	eral Motor Carrier Safety Administration
Ind	ividual's Name:
	If no, provide details:
pe mo do	te: The individual is not physically qualified to operate a commercial motor vehicle for up to the maximum 12-month riod until he/she provides a treating clinician with at least the preceding 3 months of electronic blood glucose self-onitoring records while being treated with insulin. At the certified medical examiner's discretion, the individual who es not possess at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated the insulin may qualify to operate a commercial motor vehicle for up to but not more than 3 months.
4.	How many times per day is the individual testing his/her blood glucose?
5.	Is the individual compliant with blood glucose self-monitoring based on his/her specific treatment plan?
	Comments (if necessary):
Se	vere Hypoglycemic Episodes
6.	Has the individual experienced any severe hypoglycemic episodes within the preceding 3 months? FMCSA defines a severe hypoglycemic episode as one that requires the assistance of others, or results in loss of consciousness, seizure or coma. YesNo
	If yes, provide date(s) of occurrence, whether the cause has been addressed, and associated details (attach additional pages as needed):
H	emoglobin A1C (HbA1C) Measurements
7.	Has the individual had HbA1C measured intermittently over the last 12 months, with the most recent measure within the preceding 3 months? YesNo
	If yes, attach the most recent result.
Di	abetes Complications
8.	Does the individual have signs of diabetic complications or target organ damage? This information will be used by the certified medical examiner in determining whether the listed conditions would impair the individual's ability to safely operate a commercial motor vehicle.
	a. Renal disease/renal insufficiency (e.g., diabetic nephropathy, proteinuria, nephrotic syndrome)? Yes No

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If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

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U.S. Department of Transportation

Federal Motor Carrier Safety Administration				
Indi	vidua	l's Name:		
	b.	Diabetic cardiovascular disease (e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)? YesNo		
		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)? YesNo		
		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)? YesNo		
		If yes, provide the date of diagnosis, location, type of involvement, current treatment, and whether the condition is stable:		
	e.	Lower limb (e.g., foot ulcers, amputated toes/foot, infection, gangrene)?YesNo		
		If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:		
	f.	Other? (specify condition)YesNo		
		If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:		
Pro	ogre	essive Eye Diseases		
9.	Da	te of last comprehensive eye examination:		
10.		s the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic inopathy?  YesNo		

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If yes, provide date of diagnosis:

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U.S. Department of Transportation **Federal Motor Carrier Safety Administration** Individual's Name: \_\_\_ 11. Has the individual been diagnosed with any other progressive eye disease(s) (e.g., macular edema, cataracts, glaucoma)? \_\_\_\_Yes \_\_\_\_No If yes, specify the disease(s), provide the dates of diagnoses, current treatment, and whether the condition is stable: 12. Additional Comments (attach additional pages as needed) I attest that I am a treating clinician (as defined above), that this individual maintains a stable insulin regimen and proper control of his/her insulin-treated diabetes mellitus, and that the information provided is true and correct to the best of my knowledge. Date Printed Name and Medical Credential Signature Professional License Number and State Phone Number Email

City, State, Zip Code

Street Address