North Carolina Division of Motor Vehicles
Commercial Driver's License Waiver Program

Commercial Driver License Diabetes Medical Report

New Certification ☐ Recertification ☐

Name of the Driver (Printed) ____________ Driver's License Number ____________ Date ____________

Date of Birth ____________ Signature ____________

Address ____________ City ____________ State ____________ Zip Code ____________ Area Code and Number ____________

I, the undersigned, hereby authorize Dr.________________________________to give any examination deemed necessary for the purpose of determining my physical fitness to operate a commercial motor vehicle. I give permission to this physician, and any other physicians, healthcare providers, clinics, or hospitals involved in my care, to share records and discuss my medical condition with each other and with the Division of Motor Vehicles. If requested, I agree to release to the Division of Motor Vehicles or its representatives any information concerning my condition, and any or all of the information provided to my Provider. I do hereby release, waive, and relinquish all claims against the Division of Motor Vehicles, its agents and employees, for any cause whatsoever arising out of the release of this medical information.

Date__________________________Signature of the applicant ______________________________________

Instructions to the Applicant: Please complete all the steps below. An incomplete application or any Incomplete forms may delay review of your application with requests for the missing information.

1) Sign the above release.

2) Undergo a comprehensive medical evaluation by your physician that addresses your ______________________________________(including diabetes if applicable), and any other problems that might affect your ability to operate a commercial motor vehicle safely.

3) Before your medical evaluation, please complete the following steps:

a) Complete the medical history portion of the form beforehand, and take it with you to the appointment. Leave the gray shaded Provider Comments section blank so the Provider will have a place to add any comments.

b) You or your employer should complete the Vehicle and Driving Conditions Report beforehand and take it with you to the appointment. This report should reflect any circumstances in which you expect to be driving after receiving a waiver, and include information about all types of vehicles, driving conditions, and non-driving job tasks you will be required to perform.

c) Make sure that the Provider has available all medical information regarding your medical problems and any treatment you have had over the last **five** years, either from your office chart, copies of medical information from other Providers, clinics or hospitals.

d) Other ____

4) During your evaluation complete following steps:

a) Make sure the Provider understands that you are applying for a waiver of the physical requirements for a commercial driver's license and the importance of carefully considering all of your medical history and performing a thorough physical examination.

b) Review the Vehicle and Driving Conditions Report so that the Provider has an exact understanding of your driving situation.

c) Review with the Provider your answers to the questions on this form.

d) After the physical examination, have the Provider complete the remainder of the form and the Provider's Assessment.

e) Make sure the **completed** and **signed** form is mailed to DMV **with the CDL Waiver Cover sheet**.

5) Demonstrate to the Provider that you understand diabetes and its management, including how to accurately monitor blood sugar, interpret blood sugar results, recognize and handle low blood sugar, adjust diet and exercise, and how diet, exercise, infection and other factors affect blood sugar control.

Driver Initials________________

Name:	NCDL#	Date:

Commercial Driver License Diabetes Medical Report

Medical History

Hospitalizations and Surgeries

DATE	NAME OF HOSPITAL	LOCATION OF HOSPITAL	REASON FOR HOSPITAL STAY

Medications

(prescription, over-the counter, herbal, diet supplements)

NAME	DOSE	INTERVAL	PROBLEMS BEING TREATED
Allergies			

Medical Disorders and Systems Review

Check yes if you currently have or have had within the last five years any of the following problems. Review your answers with your Provider.

Gray shaded area is for Provider to complete.

	NO	YES	Provider Comments
Vision Disorder			
Problems with color vision			
Ear or Hearing Disorder			
Endocrine Disorder			
Diabetes mellitus			
Need Medication for control			
Insulin dependent			
Significant Low blood sugar in the last three years			
Other serious reaction to medication			
Diabetic eye problems			
Muscle or nerve problems from diabetes			
Circulation problems			
Kidney problems related to diabetes			
Other problems related to diabetes			
Other gland problems			
Respiratory Disorder			
Use oxygen at home			
Emphysema or COPD			
TB (tuberculosis)			
Snoring or trouble breathing at night			
Blackouts from coughing			
Asthma or other lung problems			
Sleep apnea (uses CPAP machine) -how many nights/wk hrs/night			
Sleep disorder (narcolepsy)			
Daytime Sleepiness			

Name:	NCDL#	Date:

Medical Disorders and Systems Review (continued)

Check yes if you currently have or have had in the last five years any of the following problems.

Gray shaded area is for Provider to complete.

Review your answers with your Provider.	**NO**	**YES**	**Provider Comments**
Cardiovascular Disease			
High blood pressure			
Chest pains or angina			
Heart attack			
Stroke			
Heart rhythm problems			
Blackouts			
Shortness of breath			
Fluid problems or heart failure			
Heart murmurs or valve problems			
Heart surgery in last year			
Renal failure			
Other			
Musculoskeletal Disorder			
Back or neck problems			
Missing limbs			
Joint pains or arthritis			
Muscle weakness or paralysis			
Nerve or muscle disease			
Neurological Disorder			
Seizures or epilepsy			
Unsteadiness or dizziness			
Sudden sleep attacks			
Unexplained blackouts or collapse			
Trouble with memory or thinking clearly			
Head injury			
Stroke, mini-stroke or TIA			
Brain tumor, aneurysm, or other problems			
Other			
Mental/Emotional Condition			
On medication			
Still having symptoms			
Diagnosis:			

Alcohol and Substance Abuse — **Gray shaded area for Provider to complete.**

Check any medication or drug you use or have used in the past.	**USE(D)**	**ABUSE**	**DEPEN DENCE**	**TREAT MENT**	**Provider Comments**
Sleeping pills					
Anxiety/Nerve pills					
Medications causing drowsiness					
Regular use of medication for chronic pain					
Alcohol					
Marijuana					
Stimulants or speed					
Narcotics					
Cocaine					
Methadone					
Other addictive substances					

Name:	NCDL#	Date:

Physical Examination

APPEARANCE AND VITAL SIGNS

Appearance and Development:	Good	Fair	Poor	Comments	BMI ____	Height ______	Weight ______
Pulse:				Blood Pressure: Systolic Diastolic			

VISION

				Left	Right
Color Test (Red/Green/Yellow):	Pass	Fail	Monocular Vision	20/	20/
Corrective Lenses:	Yes	No	Yes | No	20/	20/
			Horizontal Field of Vision		

HEARING

Whisper Test (Pass or Fail): *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).*	Left	Right

Audiometric Testing (if done)	5000 Hz	1000 Hz	2000 Hz	4000 Hz	Hearing Aids?
Left					
Right					

GENERAL EXAM	**Check NE if not examined**	**NL**	**Abn**	**NE**	**Comment on abnormalities and check yes if it interferes with the safe operation of a commercial motor vehicle.**	**YES**
Eyes						
Ears						
Nasal Passages						
Mouth/Throat						
Heart	Rhythm					
	S1/S2					
	Murmurs					
	Rubs					
	Gallops					
Lungs	Air Movement					
	Rales or Ronchi					
Abdomen	Scars					
	Tenderness					
	Masses					
Neck	Scars					
	Tenderness					
	Range of Motion					
Back	Scars					
	Tenderness					
	Range of Motion					
	Strength					
Arms, Hands, Fingers	Scars					
	Amputation					
	Atrophy					
	Deformity					
	Paralysis					
	Strength					
	Range of Motion					
Legs, Feet, Toes	Scars					
	Amputation					
	Atrophy					
	Deformity					
	Paralysis					
	Strength					
	Range of Motion					
Neurologic	Rhomberg					

Pupillary Reflexes	Light	Right								
		Left								
	Accommodation	Right								
		Left								
Knee Reflexes		Right				If abnormal	Increased?		Absent?	
		Left					Increased?		Absent?	

OTHER DATA (Required tests in italics):	**Urine: SG Alb Glu**	**| Blood: HgbA1C BUN/Cr**
ECG (if available or if indicated)	**Other**	

Name:	NCDL#	Date:

Medical Provider's Assessment

If you agree with the statements below, initial them.

If you cannot confidently and truthfully agree with any statement, do not initial it.

	I certify that the information available to me is sufficient to determine that this driver is able to safely operate a commercial motor vehicle.
	I certify that, to the best of my knowledge and according to records available to me, the information that is provided in this form is complete, accurate and a true representation of the current physical condition of the driver.
	I certify that the driver's overall medical condition (the sum of all of the driver's medical problems) does not cause, routinely or intermittently, alterations of consciousness, cognition, or other functional abilities that would interfere with the safe operation of a commercial motor vehicle.
	I certify that this driver is medically fit, physically and mentally, to performing all the driving and non- driving duties required of a commercial vehicle driver as defined in the Vehicle and Driving Conditions Report for this individual.
	I certify that the driver's diabetic condition is currently well controlled.
	I certify that the driver is willing and able to adequately and accurately monitor and manage his or her diabetes.
	I certify that, to my knowledge, the driver has had no episodes of hypoglycemia requiring the assistance of another person within the last three years.
	I certify that, to my knowledge, there have been no hypoglycemic episodes causing changes in mental status that, in my opinion, would interfere with the ability to safely drive a commercial motor vehicle.
	I certify that, to my knowledge, there have been no episodes of hypoglycemia unawareness (episodes of disorientation, confusion, seizure or coma not preceded by the prodromal symptoms of hypoglycemia).

Additional comments regarding physical and mental ability to perform driving and non-driving job tasks, risk of altercations in mental status, or the need for additional medical evaluation prior to making a fitness determination:

I certify that I am a board certified or board eligible physician, nurse practitioner, or physician assistant and am competent to evaluate the driver's medical condition, including diabetes, as it pertains to driving fitness.

Medical Provider's Name (printed) and License Number	**Date of Examination**
Address	
City, State, Zip Code	**Signature**
Area Code and Number	**Date**

North Carolina Division of Motor Vehicles
Commercial Drivers License Waiver Program

Vehicle and Driving Conditions Report

Status of the driver	Applied/accepted to truck driving school		Currently enrolled student in truck driving school	
	Unemployed		Hired pending exemption	
	Currently employed			

Employer ______ Address ______ City ______ State ______ Zip Code ______ Area Code and Number ______

Name of the Driver ______ Date of Birth ______ License Number ______

FORM COMPLETED BY

Printed Name ______ Signature ______ Date Completed ______

If the driver operates more than one type of vehicle, check all that apply.

TRUCK	**Gross Vehicular Weight**						
			Drive Train Information	Number of axles			
				Number of manual forward speeds			
				Number of auxiliary forward speeds			
				Number of rear axle transmission forward speeds			
				Transmission type: Manual		Automatic	
			Braking	Manual		Powered		Airbrakes	
			Steering	Manual		Powered	
			For passenger vehicles, seating capacity:				

TRAILER(S)	**Gross Vehicular Weight**		**Number towed at one time**	1 2 3	Van		Flatbed	
					Bin		Tanker	
					Pole		Other	

MODIFICATIONS MADE FOR THE DRIVER (if applicable)	(include relevant photographs)

TIME AND DISTANCE		Round trip distance	Hours per 7 day week	Hours per 24 hour day	Daylight hours per week	Nighttime hours per week
	Average					
	Maximum					

TRAFFIC AND ROAD CONDITIONS	Secondary roads		Rural	
	Interstate highway		Urban	

TRANSPORTED CARGO	List

NON-DRIVING ACTIVITIES	Hitching and unhitching		Loading and unloading	
	Covering or tying down		Filling or emptying tankers	
	Other (describe)			

TYPE OF DRIVER OPERATION		
	Relay	
	Single driver	
	Sleeper team	
	Owner-operator	
	Non-driving individuals accompanying the driver	

Number of years of driving experience:	Total years driving experience	
	Number driving the vehicle described above	

CDL WAIVER COVER SHEET

ATTENTION: THIS PAGE MUST BE COMPLETED AND INCLUDED WITH ANY WAIVER DOCUMENTS THAT ARE SUBMITTED

NAME____

DATE OF BIRTH____

DRIVERS LICENSE NO.____

CIRCLE TYPE OF WAIVER: **DIABETIC** **VISION** **LIMB**

MAIL OR FAX INFORMATION:

MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER
RALEIGH, NC 27697
FAX NO: (919) 733-9569

IMPORTANT!!!

PLEASE INCLUDE THIS PAGE WITH YOUR COMPLETED FORMS WHEN FAXING OR MAILING WAIVER DOCUMENTATION TO DMV.