

LABOR RELATIONS



July 10, 1997

Robert C. Pritchard
Director, Motor Vehicle Services Division
American Postal Workers Union,
AFL-CIO
1300 L Street, NW
Washington, DC 20005-4107

Dear Mr. Pritchard:

This letter responds to your inquiry concerning the use of the appropriate medical form for a Department of Transportation (DOT) physical examination.

Enclosed is a copy of the most current American Trucking Association form which is to be utilized for DOT examinations.

If you have any questions regarding the foregoing, please contact Joyce Ong of my staff at (202) 268-6248.

Sincerely,

A handwritten signature in cursive script, appearing to read "P. Sgro".

Peter A. Sgro
Acting Manager
Contract Administration APWU/NPMHU

Enclosure

DO NOT RETURN TO ATA

(SEE DEPARTMENT OF TRANSPORTATION REQUIREMENTS)

Date of Examination _____ New Certification
Recertification
Check Here If Not Qualified

To Be Filled In By Medical Examiner (Please Print):

Driver's Name _____

Address _____

Soc. Sec. No. _____ Date of Birth _____ Age _____

Health History:

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nervous stomach	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Head or spinal injuries
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, or fainting
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease or injury

If answer to any of me above is yes, explain _____

General appearance & development: Good _____ Fair _____ Poor _____

Vision: For Distance: Right 20/_____ Left 20/Both _____ 20/_____ Without corrective lenses With corrective lenses, if worn

Evidence of disease or injury: Right _____ Left _____

Color Test _____ Horizontal kid of vision: Right _____ Left _____

Hearing: Right ear _____ Left ear _____

Disease or injury _____

Audiometric test: (if audiometer is used to test hearing) Decibel loss at 500 Hz _____ 1,000 Hz _____ 2,000 Hz _____ 4,000 Hz _____ 6,000 Hz _____

Throat: _____

Thorax: Heart _____

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after exercise _____

Lungs _____

Abdomen: Scars _____ Abnormal masses _____ Tenderness _____

Hernia: Yes _____ No _____ If so, where? _____ Is truss worn? _____

Gastrointestinal: Ulceration or other diseases: Yes _____ No _____

Genito-Urinary: Scars _____ Urethral discharge _____

Reflexes: Romberg _____

Pupillary _____ Light R _____ L _____

Accommodation: Right _____ Left _____

Knee jerks: Right: Normal _____ Increased _____ Absent _____

Left: Normal _____ Increased _____ Absent _____

Remarks: _____

Extremities: Upper _____ Lower _____ Spine _____

Laboratory and Other Special Findings: Urine: Spec. Gr. _____ Alb. _____ Sugar _____

Other Laboratory Data (Serology, etc) _____

Findings: Radiological Data _____ Electrocardiograph _____

Controlled Substances Testing: Controlled substances test performed, In accordance with Subpart H Not in accordance with Subpart H

3 Controlled substances test NOT performed

General Comments: _____

Name of Medical Examiner (Print) _____ Signature _____

Address of Medical Examiner _____

MEDICAL EXAMINER'S CERTIFICATE TO BE COMPLETED ONLY IF DRIVER IS FOUND QUALIFIED

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined

(Driver's name (Print))

In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41 through 391.49) and with knowledge of his/her duties, I find him/her qualified under the regulations. Expiration date of certificate: _____

Qualified only when wearing: Corrective lenses Hearing aid
 Medically unqualified unless accompanied by a _____ waiver
 Medically unqualified unless driving within an exempt intracity zone
A completed examination form for this person is on file in my office.

(Area Code/Phone No.) _____ (License/Certificate No.) _____ (State) _____

(Medical Examiner: (Print Name and Title)) _____ (Signature) _____

(Signature of Driver)

(Address of Driver)

The following will be completed only when the visual test is conducted by a licensed ophthalmologist or optometrist.

(Date of examination)

(Name of Ophthalmologist or Optometrist (Print))

(Address of Ophthalmologist or Optometrist)

(Signature of Ophthalmologist or Optometrist)

INSTRUCTIONS ON REVERSE SIDE