June 19, 1998

AREA MANAGERS, HUMAN RESOURCES
MANAGERS, DISTRIBUTION NETWORKS
MANAGERS, TRANSPORTATION AND NETWORKS
MANAGERS, VEHICLE MAINTENANCE FACILITIES
MANAGERS, PLANT MAINTENANCE

SUBJECT: Commercial Drivers License (CDL) Employee Physicals
(Supersedes all previous memoranda)

To be consistent with the trucking industry and our own contract driver requirements, U.S. Postal Service policy voluntarily parallels Department of Transportation (DOT) requirements as they pertain to physicals for Commercial Drivers License (CDL) employees. These requirements include issuance of a Medical Card.

Every CDL employee is required to have a standard DOT CDL physical every two years. The physical will be scheduled by postal management, occur on the clock at a Postal Service Medical Unit or Postal Service Contract Medical Facility, and be paid for by the Postal Service. CDL drivers are not authorized to have their DOT physicals conducted at medical facilities other than Postal Medical Units or Postal Contract Medical facilities.

PS Form 2465 is no longer used for DOT physicals. The Physical Examination Form, which meets the DOT requirements and is available from J.J. Keller Company, is to be used by medical personnel for the physicals. When the CDL employee passes the DOT physical, a Medical Card will be issued by medical personnel. This card is evidence that enables an employee to meet physical requirements when renewing his/her CDL with state licensing authorities. If a CDL employee fails the physical, management must immediately confer with Labor Relations personnel at the local level for guidance regarding the next applicable procedure.

If you have any questions regarding this policy, contact John Hernandez at 202-268-3553. Thank you for your support in ensuring a safer CDL driver workforce. With your help, we can keep the Postal Service and our employees free from risk of serious consequences.

J. Michael Krop
Manager
Transportation Modal Operations
and Requirements

cc: Mr. Eddy
# Physical Examination of Drivers

**Name:**

**Address:**

**Social Security No.:**

**Date of Birth:**

**Age:**

### New Certification

**Date:**

**Certification:**

**Health History**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head or spinal injuries</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Extensive cardiovascular disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Suffering from any other disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Permanent defect from illness, disease or injury</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Any other nervous disorder</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If answer to any of the above is 'yes', explain:

### Physical Examination

**General Appearance and Development:** Good: ____________ Fair: ____________ Poor: ____________

**Vision:** For distance: Right 20/20 Left 20/20 Both 20/20

- Without corrective lenses: ____________ With corrective lenses if worn: ____________

**Color Test:** Right: ____________ Left: ____________

**Hearing:** Right ear: ____________ Left ear: ____________

**Temperature:** ____________

**Blood pressure:** Systolic ____________ Diastolic ____________

**Blood:**

- Syphilis: ____________
- Gonorrhea: ____________
- Tuberculosis: ____________
- Any other disease: ____________

**Eye:**

- Keratitis: ____________
- Conjunctivitis: ____________
- Osteomyelitis: ____________
- Any other disorder: ____________

**Ear:**

- Acute otitis media: ____________
- Chronic otitis media: ____________

**Heart:**

- Valvular disease: ____________
- Rhythm disturbances: ____________

**Respiratory:**

- Tuberculosis: ____________
- Any other disease: ____________

**GI:**

- Ulceration or other disease: Yes: ____________ No: ____________

**GU:**

- Urinary tract infection: Yes: ____________
- Abnormal renal function: ____________

**Physiological Reflexes:**

- Romberg test: ____________
- Pupillary light reflex: Right: ____________ Left: ____________
- Knee jerk: Right: Normal ____________ Increased ____________ Absent ____________
- Left: Normal ____________ Increased ____________ Absent ____________

**Laboratory and Other Special Findings:**

- Urine: Spec. Gr. ____________ Ab. Sugar ____________

**Controlled Substances Testing:**

- Controlled substances test performed: ____________
- Not controlled substances test: ____________

**Medical Examiner's Certificate**

I certify that I have examined ____________ in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and find them qualified or disqualified under the regulations.

**Medical Examiner:**

**Address:**

**Date:**

**Signature:**

**NOTE:** Medical Examiner's Certificate must be retained in Driver's Qualification File.

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**PERSONNEL-38**

6/94