LOGISTICS

UNITED STATES POSTAL SERVICE

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 bymedii 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 Hemandez 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.

for J. Michael Krop
Manager
Transportation Modal Operations
and Requirements

cc: Mr. Eddy

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PHYSICAL EXAMINATION OF DRIVERS

Name: _____

Address: _____

Social Security No.: _____ Date of Birth: _____ Age: _____

☐ New Certification ☐ Recertification

HEALTH HISTORY

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

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

PHYSICAL EXAMINATION

GENERAL APPEARANCE AND 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 field of vision: Right _____° Left _____°

HEARING: Right ear _____ Left ear _____ Disease or injury _____

AUDIOMETRIC TEST (complete only if audiometer is used to test hearing) decibel loss at 500 Hz _____

at 1,000 Hz _____ at 2,000 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 disease: 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.) _____

Radiological data _____ Electrocardiograph _____

CONTROLLED SUBSTANCES TESTING:

☐ Controlled substances test performed–

☐ In accordance with subpart H ☐ Not in accordance with subpart H

☐ Controlled substances test NOT performed

GENERAL COMMENTS _____

(Date of examination) (Address of Medical Examiner) (Name of Medical Examiner) (Print)

(Title) (License or Certification No.) (State)

(Signature of Medical Examiner)

☐ **CHECK HERE IF NOT QUALIFIED**

NOTE: This section to be completed only when visual test is conducted by a licensed optometrist or ophthalmologist.

(Date of examination) (Address of examiner) (Name of examiner) (Print)

(Signature of examiner)

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 391.41-391.49) and with knowledge of his/her duties, I find him/her qualified under the regulations.

☐ Qualified only when wearing corrective lenses. ☐ Medically unqualified unless accompanied by a _____ waiver.

☐ Qualified only when wearing a hearing aid. ☐ Medically unqualified unless driving within an exempt intracity zone

A completed examination form for this person is on file in my office at _____ (Area Code & Telephone Number)

(Expiration Date) (Name of Medical Examiner) (Print) (Signature of Medical Examiner)

(Title) (License or Certificate No.) (State in Which Licensed)

(Signature of driver) (Address of driver)

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

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