DOT Medical Exams – INTERstate and INTRAstate Drivers
Insulin Treated Diabetes Mellitus (ITDM) Assessment

Not applicable to Washington School Bus Drivers – School Bus Drivers refer to OSPI document #1643

Patient Instructions

Updated: 04-15-19 | Replaces 11-21-18

This DOT exam process exists if you require insulin to control Diabetes, which replaces the previous waiver programs. ***Documentation must be submitted prior to scheduling your exam,*** so it may be reviewed by the NRCME examiner prior to your appointment.

Documentation Requirements

In order for the examiner to make a clearance determination, the following *must be submitted to the clinic prior to scheduling your exam:*

1) FMCSA Form MCSA-5870 filled out completely and signed by your Treating Clinician.
2) Signed MultiCare ITDM *"Treating Clinician letter."*
3) MultiCare form *"Vision Evaluation DOT Medical Exam-Insulin Treated Diabetes Mellitus Assessment"*
4) Complete medical records of all appointments with your Treating Clinician within the last 45 days (chart notes – not After Visit Summaries)
5) 90 days of electronic blood glucose logs, documenting daily blood sugars.

Additional documentation is needed for some patients

6) Type 1 diabetics (completely insulin dependent), and Type 2 diabetics using insulin for control with use of supplemental Humalog as needed.
   a) Complete medical record of a visit with an endocrinologist completed within the last 6 months.

MultiCare provides DOT exams with ITDM Assessments at these locations

Submit above documentation to this location for review prior to scheduling your appointment.

MultiCare Occupational Medicine-Kent
222 State Ave. N.
Kent, WA 98030
888-280-5513
follow phone menu to Kent clinic

Immediate Clinic Burien Occupational Medicine
15500 1st Ave So. Suite 106
Burien, WA 98148
206-242-0855

Additional Fees Apply

MCSA-5870

OMB Control Number: 2126-0006
Expiration Date: 11/30/2021

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

Individual's Name: _____

INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

Name: _____ **DOB**: _____

Driver's License Number (if applicable): _____ State: _____

This individual is being evaluated either to determine whether he/she meets the physical qualification standards of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle or because the individual has recently experienced a severe hypoglycemic episode. A treating clinician should complete this form to the best of his/her ability based on his/her knowledge of the individual's medical history. Completion of this form does not imply that a treating clinician is making a medical certification decision to qualify the individual to drive a commercial motor vehicle. Any determination as to whether the individual is physically qualified to drive a commercial motor vehicle will be made by a certified medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines a treating clinician as a healthcare professional who manages, and prescribes insulin for, treatment of the individual's diabetes mellitus as authorized by the healthcare professional's applicable State licensing authority.

Instructions to the Individual:

When you are being evaluated prior to a medical certification examination, the certified medical examiner must receive this form and begin the examination no later than 45 calendar days after a treating clinician signs this form.

When you are being evaluated after a severe hypoglycemic episode, you must retain this form and give it to the certified medical examiner at your next medical certification examination.

Insulin-Treated Diabetes Mellitus Diagnosis

1. Date insulin use began: _____

Blood Glucose Self-Monitoring Records

2. Has the individual maintained at least the preceding 3 months of ongoing blood glucose self-monitoring records while being treated with insulin that are measured with an electronic glucometer that stores all readings, records the date and time of readings, and from which data can be electronically downloaded?
   _____Yes _____No

3. Has the individual provided at least the preceding 3 months of electronic self-monitoring records while being treated with insulin from his/her glucometer to the treating clinician for review?
   _____Yes _____No

If no, provide details:
_____

Note: The individual is not physically qualified to operate a commercial motor vehicle for up to the maximum 12-month period until he/she provides a treating clinician with at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with insulin. At the certified medical examiner's discretion, the individual who does not possess at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with 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?
_____Yes _____No

Comments (if necessary): _____
_____

Severe 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.*
_____Yes _____No

If yes, provide date(s) of occurrence, whether the cause has been addressed, and associated details (attach additional pages as needed):
_____
_____

Hemoglobin 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?
_____Yes _____No

If yes, attach the most recent result.

Diabetes 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

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

_____

b. Diabetic cardiovascular disease (e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)?
_____Yes _____No

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)?
____Yes ____No

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)?
____Yes ____No

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)?
____Yes ____No

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

f. Other? (*specify condition*)_____
____Yes ____No

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

Progressive Eye Diseases

9. Date of last comprehensive eye examination:_____

10. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?
___Yes ____No

If yes, provide date of diagnosis: _____

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

_____ _____
Street Address City, State, Zip Code

DOT Exams with Insulin Treated Diabetes Mellitus Assessment

Treating Clinician Letter

Effective 11-21-18

Dear Medical Provider,

Your patient will be scheduling an examination for medical clearance to obtain an interstate commercial driver's license (CDL) under the U.S. Department of Transportation Federal Motor Carrier Safety Administration (DOT FMCSA). The clearance determination will be made by a MultiCare provider on the DOT FMCSA National Registry of Certified Medical Examiners (NRCME).

Required documentation for our examination includes the Treating Clinician to a) complete and sign form MCSA-5870; b) provide complete medical records of the last 45 days' appointments with your patient; and c) your signed confirmation below.

I am the Treating Clinician for _____ ("Patient"), a diabetic taking insulin.

In addition to information on form MCSA-5870, I confirm the Patient has none of the following disqualifying factors:

- Any episode of severe hypoglycemia within the previous 6 months.
  ("Severe" hypoglycemic episodes are defined as hypoglycemia that requires the assistance of others or results in loss of consciousness, seizure, or coma.)
- Blood sugars less than 60mg/dL demonstrated in current glucose logs
- Hypoglycemia appearing in the absence of warning symptoms
- Uncontrolled diabetes, as evidence by HgA1C greater than 10%
- Stage 3 or 4 diabetic retinopathy (permanent disqualification if either severe proliferative or non-proliferative diabetic retinopathy)
- Signs of diabetic complications or target organ damage
- Inadequate record of self-monitoring blood glucose

Based on review of the Patient's diagnostics and my recent examination, it is my opinion that the patient has a clear understanding of their disease, and the signs and symptoms to watch for that would impair his/her driving.

It is my opinion, that my patient is safe to operate a commercial vehicle without risk to public safety.

Clinician Signature	**Date**
Print Clinician Name	**Telephone**

Clinic Name, Address, State Zip

MultiCare

Occupational Medicine Services

multicareoccmed.org **immediateclinic.com**

Vision Evaluation

DOT Medical Exam

Insulin Treated Diabetes Mellitus Assessment

Driver: Have this form completed and signed by your Ophthalmologist or Optometrist and return to the clinic.

Driver Information

Last Name: First Name: MI:

Address:

City State Zip

DOB (MM/DD/YYYY) / /

This individual will be undergoing an insulin treated diabetes mellitus assessment in order to be medically cleared by a Federal Motor Carrier Safety Administration (FMCSA) medical examiner to obtain a commercial driver's license. Part of the assessment is an eye examination (required on an annual basis) by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving.

PLEASE CHECK/FILL IN REQUESTED INFORMATION

1. I am an ophthalmologist: _____ I am an optometrist: _____
2. Date of most recent examination: _____
3. Distant visual acuity (provide both if applicable)

Uncorrected: _____		Corrected: _____		Corrective lens type
Right eye:	20 / _____	Right eye	20 / _____	Glasses ____
Left eye:	20 / _____	Left eye:	20 / _____	Contact lens ____

4. Field of vision (FOV)*:

   Right eye: _____ degrees (quantitative value required)

   Left eye: _____ degrees (quantitative value required)

   Test used to determine values: _____

*Note: If the patient has received laser treatment, and in your medical opinion you believe the patient's FOV is compromised, FMCSA recommends formal perimetry to determine if the driver meets the FOV standard.

5. Color Vision

   Is the patient able to identify correctly the standard red, green and amber traffic control signal colors?

   Yes _____ No ____

   Note: If color testing results are inconclusive, it is discretionary whether to administer a controlled test using an actual traffic signal to determine the individual's ability to recognize red, green, and amber.

6. Diabetic retinopathy. An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).

   Does the patient have diabetic retinopathy? Yes: _____ No: _____

   If yes to above: Mild: _____ Moderate: _____ Severe: _____

   Proliferative: Stable: _____ Unstable: _____

   Nonproliferative: Stable: _____ Unstable: _____

   Treatment: _____

   Date diagnosed: _____

   Surgeries/procedures: _____

   Requires recheck in _____ months.

7. Does the patient have macular edema? Yes ____ No ____
8. Does the patient have cataract(s)? Yes ____ No ____
9. Does the patient have any other medical diagnosis related to vision? Yes ____ No ____

   If yes, what _____

10. If yes to any of the conditions listed above, are any unstable? Yes ____ No ____

    If yes, which condition(s) _____

11. In your medical opinion, is monitoring required more often than annually? Yes ____ No ____

    If yes, how often? _____

12. In your medical opinion, does the patient possess any vision problem that might impair safe driving?

    Yes ____ No ____

    If yes, please explain: _____

    _____

13. I hereby certify that in my medical opinion, the applicant's medical condition allows them to safely operate a commercial vehicle while using insulin for the control of diabetes mellitus.

    Yes ____ No ____

14. Ophthalmologist or Optometrist Identification:

    Last Name: _____ First Name: _____

    Medical license # _____ State of issue: _____

    Signature: _____ Date: _____