Date

Dr. Name

Address

City State Zip

Re: \_\_\_\_\_\_\_\_\_\_\_, DOT Commercial Motor Vehicle Driver Medical Exam

Dear Dr. \_\_\_\_\_\_\_,

The above driver came to our clinic for a DOT medical certificate to drive a commercial motor vehicle. Before qualifying the driver, we ask for your assistance in determining if they have met the necessary medical criteria for an individual with a history of a traumatic brain injury.

Although we must obtain and consider the opinions of the treating physician, it is our responsibility to make the final driving status determination.

Please answer the following questions:

1. Did the individual have loss of consciousness and for what period of time?

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1. What are the symptoms and level of severity of the individual’s cognitive, psychosocial, sensory, or motor function impairment?

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1. Has treatment been shown to be adequate, effective, safe, and stable?

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1. Is the nature and severity likely to interfere with the ability to drive a CMV safely?
* Yes
* No

Please sign and date below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature Date

Thank you for your assistance.