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

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #
_____
(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ○ Yes ○ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ **Yes** ○ **No** ○ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? ○ **Yes** ○ **No** ○ **Not Sure**
If "yes," please describe below.

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

DOT Medical Exam Costs

If the exam is not being billed to insurance or an employer, this amount is payable at check-in. If the medical exam requires any additional procedures (EKG, blood work, for smokers there can be a required pulmonary test, etc.), they are payable at check-out.

If you fail any part of the exam conducted by a **medical assistant** (vision, blood pressure, urine analysis, etc.) and **do not see a provider** you have the following options:

1) Have any failure retested at a later time, additional costs will be incurred for any repeated labs (urine analysis). Retesting blood pressure and/or vision is free. If all failures are resolved positively and the provider finds no further failures, you will be issued a driver's card.

2) Request a partial refund. You will not get a driver's card from the clinic. You will be refunded the difference between the prepaid medical exam total cost and the charge for a nurses' visit plus the charge for the urine analysis.

Restarting the DOT medical exam process, at a later date, will again cost you the original cost of the exam.

If you fail any part of the exam conducted by a **provider**, no refund will be allowed; you have the following options:

1) Complete required items (sleep study, cardiologist approval, weight loss, blood pressure, etc.); additional costs will be incurred. Cost depends on additional procedures done or paperwork needed to be completed. If all failures are resolved positively and the provider finds no further failures, you will be issued a driver's card.

2) Don't complete the required items. No driver's card will be issued. No refund.

Upon successful completion of the medical exam, interstate drivers must present the medical examiner's certificate to a state DMV Office.

Misrepresentation of medical conditions or prescribed medications may result in immediate disqualification that will be reported to the FMCSA.

I have read the above information and understand its contents.

Patient Printed Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

ACCOUNT#

FPUCC SELF-PAY OPTIONS FOR NON-COVERED SERVICES

Date: ___/___/___

Option A:

I, _____, the patient/guardian, acknowledge I understand and agree that:

1. Franklin Park Urgent Care Center (FPUCC) is a participating provider with _____ (Insurance Ins. Company) and/or _____ (Secondary Ins. Company) and/or _____ (Tertiary Ins. Company).
2. I am currently covered by the insurance company(s) stated above.
3. The health plan I am covered under includes benefits for most of the services provided by Franklin Park Urgent Care.
4. I understand the service I am requesting today may be covered by my primary healthcare provider or a different healthcare facility.
5. The service I am requesting today is _____.
6. I do not wish FPUCC to submit a claim to my insurance company for services provided to me by FPUCC.
7. I elect to pay for all services provided by Franklin Park Urgent Care at their discounted rates.
8. I have read FPUCC Self-Pay options for non-covered services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.
9. I am freely choosing to self-pay for services after having asked FPUCC about payment options and having carefully considered those options.

Option B:

I, _____, the patient/guardian, attest I do not have medical health insurance.

Signature of Patient or Guardian: _____.

Printed Name of Patient or Guardian: _____.

Relation of Responsible Party: _____ (self, parent, guardian, etc.).

FRANKLIN PARK URGENT CARE CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to us. We will maintain the privacy of your health information and we will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

A federal law, commonly known as HIPAA, requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As part of this process, at your request, we are required to provide you with a document detailing our clinic's Notice of Privacy Practices. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

We are requesting you sign this document acknowledging you have been informed of your right to a copy of our Notice of Privacy Practices. If you desire a copy of this document, at this time, let the receptionist know and they will provide you with a copy of the document.

This acknowledgement form will be kept in your medical record.

If you have any questions about this Notice, please contact the Office Manager at (509)489-1150.

By my signature below, I acknowledge I have either received a copy of the Franklin Park Urgent Care Center Notice of Privacy Practices document or I elected to not receive the document, even though it was available to me upon my request.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship to patient

FRANKLIN PARK URGENT CARE CENTER

5904 North Division, Spokane, Washington 99208 (509)489-1150

PATIENT INFORMATION (Please print clearly)

LAST NAME	FIRST	MI	SEX	RACE	MARITAL STATUS	BIRTHDATE

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE

HOME PHONE	BUSINESS PHONE	CELL PHONE	SOCIAL SECURITY #	EMAIL ADDRESS
( )	( )	( )		

Nearest Friend or Relative not Residing with You	RELATIONSHIP	PHONE	ADDRESS
		( )	

REFERRED BY	ALLERGIES or SPECIAL MEDICAL PROBLEMS

REGULAR DOCTOR'S NAME and PHARMACY LOCATION	MEDICATIONS YOU ARE CURRENTLY TAKING (NAME, DOSAGE, FREQUENCY)

FINANCIAL RESPONSIBILITY (If other than patient. Please print clearly)

LAST NAME	FIRST	MI	PHONE	RELATIONSHIP	DATE OF BIRTH
			( )		

STREET ADDRESS	CITY	STATE	ZIP CODE	SOCIAL SECURITY #

EMPLOYMENT (Please print clearly)

EMPLOYER	ADDRESS, CITY, STATE, ZIP	PHONE	OCCUPATION
		( )	

SPOUSE'S NAME	SPOUSE'S EMPLOYER	PHONE
		( )

GIVE A BRIEF STATEMENT OF PRESENT MEDICAL PROBLEM and DURATION OF PROBLEM

ON THE JOB INJURY? (Y,N) ____

METHOD OF PAYMENT

Our office policy requires full payment at the time of service for cash paying patients. For patients currently covered by a contracted insurance company this includes any required co-payments. Patients not required to make a payment at time of service include patients covered by Public Assistance, Medicare and State Industrial Insurance.

This account will be paid by (circle one): CASH CHECK CHARGE CARD DEBIT CARD

I hereby give permission for _____
(print minor's full legal name here)
to receive treatment and any tests deemed necessary by the doctor on duty at Franklin Park Urgent Care Center. I understand that my insurance company may not cover or pay for these services. I agree to be personally responsible for the total payment of this bill if this service is not covered. In event of default, all attorney fees and collection costs will be incurred by the debtor. By providing your email address, you agree to receive information about services and offers from the clinic.

Signature (and relationship) _____ Date _____