PHYSICIAN'S STATEMENT OF EXAMINATION

Authority: MCL 480.13; **Compliance:** Voluntary; however, failure to complete this form will result in a denial of the applicant's medical waiver application.

Instructions for Driver/Applicant

Please have treating physician complete this statement. It is your responsibility to mail the completed form to the address below. Applications may be submitted by email to MSP-CVEDmedwaiver@michigan.gov or mailed to:

Michigan State Police
Commercial Vehicle Enforcement Division Medical Waiver Unit
P.O. Box 30634
Lansing, Michigan 48909-0634

Release of Information (Application cannot be processed without signature) To be completed by Intrastate Medical Waiver applicant or applicant's representative. Please print.			
Applicant's Name (Last, First, Middle)		Date of Birth	Driver's License Number
Street Address	City	State	ZIP Code
Address Line 2		Daytime Phone Number	
I hereby authorize and request that information regarding my medical condition be released to the Michigan State Police.			
Applicant's Signature			Date

Instructions for Physician

The Michigan State Police (MSP) asks for assistance in determining the physical and mental condition of the patient. Your professional opinion, the answers to these questions, and any other pertinent information will help the MSP assess the patient's ability to safely operate a commercial motor vehicle. Confidential information may be mailed directly to the MSP at the address shown above. The exam must be completed pursuant to 49 CFR 391.43.

Please fill out any additional sections below that are also pertinent to the patient.

Section(s) to be Completed by Physician:

- ☐ Section A - Neurological or Neuromuscular Diseases (Page 2)
- ☐ Section B - Other Medical Disorders, General Medical Conditions (Pages 3-5)
- ☐ Section C - Drugs and Alcohol (Page 5)
- ☐ Section D - Psychological Evaluation (Pages 6-7)
- ☑ Section E - Comments (Must be completed for all applicants; pages 7-8)
- ☑ Section F - Physician's Certification (Must be completed for all applicants; page 8)

Note: The physician must complete the Comments section (section E) and the Physician's Certification (section F).

Applicant's Name	Application Date

Section A: Neurological and Neuromuscular Diseases

(The physician must fill out the parts below that are pertinent to the patient)

I. Disease Causing Loss or Impairment of Consciousness or Confusion

- ☐ Epilepsy - Type
- ☐ Narcolepsy
- ☐ Cerebral Vascular Disease/Insufficiency (Complete the Atherosclerosis/Heart Disease Section on pages 3-4)
- ☐ Vasovagal Syncope
- ☐ Other (Open and closed head injuries, craniotomies, etc.)

If other, please explain.

Related Information

Age of Onset of Illness	Date of Last Seizure or Episode	Frequency of Episodes

Has the patient reported a seizure or episode within the last 12 months?
☐ Yes ☐ No

Did the patient experience a loss or impairment of level of consciousness?
☐ Yes ☐ No

Has the patient reported a seizure or episode within the last 24 months?
☐ Yes ☐ No

	Start Date	Medication	Dosage
Current Medication and Dosage			
	Start Date	Medication	Dosage

Is there a reasonable medical certainty that the last seizure or episode resulted from a medically supervised change in medication or dosage?

☐ Yes ☐ No If yes, please explain:

Has the patient had any adverse reaction to treatment or medication?

☐ Yes ☐ No If yes, please explain:

II. Other Limiting or Progressive Neurological or Neuromuscular Diseases

Cerebral Palsy, Paraplegia, Muscular Dystrophy, Parkinsonism, Multiple Sclerosis, etc.

Specific Diagnosis	Age of the Patient at Onset of Disease

Please describe the patient's neuromuscular condition, including changes that are likely in the future.

	Start Date	Medication	Dosage
Current Medication and Dosage			
	Start Date	Medication	Dosage

Is the patient's disease/condition adequately controlled with medication?
☐ Yes ☐ No

Applicant's Name	Application Date

Section A: Neurological and Neuromuscular Diseases (Continued)

Do you believe the patient is capable of safely operating a commercial motor vehicle based on the current medical condition, including medication?

☐ Yes ☐ No If no, please explain:

III. Disease Affecting Cognition

☐ Dementia or Senility ☐ Poor Memory ☐ Sleep Apnea ☐ Impairment of Judgement ☐ Other

Specific Diagnosis

Please describe the severity of the illness, treatment, and prognosis.

Section B: Other Medical Disorders, General Medical Conditions

(The physician must fill out the parts below that are pertinent to the patient)

I. Diabetes and Other Metabolic Disorders

Diabetes ☐ Yes ☐ No	Type of Diabetes ☐ Type 1 ☐ Type 2	Age of the Patient at Onset of Illness
Insulin Injections ☐ Yes ☐ No	Start Date	Strength / Frequency
Does the patient follow diet instructions? ☐ Yes ☐ No	Is the patient responsible in the management of the disease? ☐ Yes ☐ No	

Comments

Reaction Episodes (Those causing loss or impairment of level of consciousness)

Hypoglycemic ☐ Yes ☐ No	Frequency	
Hyperglycemic ☐ Yes ☐ No	Frequency	
Renal Disease ☐ Yes ☐ No	Blood Urea Nitrogen (BUN) Value	Creatinine Value

If yes to Hypoglycemic or Hyperglycemic, was the episode unusual in nature for the patient?

☐ Yes ☐ No If yes, please explain

Date of Last Episode

Symptoms	Impairment of Level of Consciousness ☐ Yes ☐ No	Loss of Judgement ☐ Yes ☐ No
	Loss of Motor Skills ☐ Yes ☐ No	Difficulty in Recalling the Episode ☐ Yes ☐ No

If any response was answered yes, please explain.

Has the patient's condition stabilized?

☐ Yes ☐ No

Is there reasonable medical certainty the last episode resulted from a medically supervised change in medication or dosage?

☐ Yes ☐ No If yes, please explain

Applicant's Name	Application Date

Section B: Other Medical Disorders, General Medical Conditions (Continued)

Date of Last Blood Glucose Test	Blood Glucose Level	Frequency of Test
Date of Last A1C Test	A1C	Frequency of Test

Vision Problems
☐ Yes ☐ No If yes, please describe.

II. Atherosclerosis/Heart Disease

Diagnosis

Peripheral Vascular Disease ☐ Yes ☐ No	Location of Disease		
Cerebral Vascular Disease ☐ Yes ☐ No	Comments		
Coronary Vascular Disease ☐ Yes ☐ No	Comments		
Angina ☐ Yes ☐ No	Frequency	Date of Onset	Angina During Driving ☐ Yes ☐ No
Dyspnea ☐ Yes ☐ No	Comments		
Syncope (Near or confusion) ☐ Yes ☐ No	Frequency		Date of Last Syncope
Arrhythmia ☐ Yes ☐ No	Frequency	Type	
Infarction ☐ Yes ☐ No	Comments		
Congestive Failure ☐ Yes ☐ No	Ever ☐ Yes ☐ No		
Defibrillator ☐ Yes ☐ No	Comments		
Pacemaker ☐ Yes ☐ No	Comments		
Hypertension ☐ Yes ☐ No	Blood Pressure	Heart Rate	

Current Medication and Dosage	Start Date	Medication	Dosage
	Start Date	Medication	Dosage

Has the patient had any adverse reaction to medication or treatment for the condition?

☐ Yes ☐ No If yes, please explain:

Has the patient reached maximum recovery period?

☐ Yes ☐ No If yes, please explain:

Applicant's Name	Application Date

Section B: Other Medical Disorders, General Medical Conditions (Continued)

Is the Atherosclerosis/heart disease condition medically treatable?

☐ Yes ☐ No Please explain.

How will this medical condition affect patient's ability to safely operate a commercial motor vehicle?

III. General Medical Conditions (Not discussed in other sections)

Diagnosis

	Start Date	Medication	Dosage
Current Medication and Dosage			
	Start Date	Medication	Dosage

Has the patient had any adverse or other reaction to treatment or medication?

☐ Yes ☐ No Please explain.

Do you recommend driving restrictions?

☐ Yes ☐ No Please explain.

Section C: Drugs and Alcohol (The physician must fill out the parts below that are pertinent to the patient)

Does the patient have any clinical evidence, or do you have personal knowledge of the patient's addiction or habituation to illegal drugs, alcohol, or prescriptions?

☐ Yes ☐ No If yes, indicate drug and duration of addiction.

Has the patient attended residential treatment or hospitalization for condition?

☐ Yes ☐ No

If yes, indicate dates of treatment and hospitalization.

Is the patient currently in substance abuse treatment?

☐ Yes ☐ No

If yes, where? Frequency and Duration of Therapy

Is there evidence of physical complications from alcohol, illegal, or prescription drug abuse?

☐ Yes ☐ No If yes, please explain.

Has the patient been advised to abstain from addictive substances?

☐ Yes ☐ No

Has the patient followed your recommendations for treatment or therapy?

☐ Yes ☐ No

Has the patient been prescribed Antabuse?

☐ Yes ☐ No

Is the patient's Antabuse monitored?

☐ Yes ☐ No If yes, please explain.

What is your professional prognosis for the patient's condition?

Applicant's Name	Application Date

Section D: Psychological Evaluation (The physician must fill out the parts below that are pertinent to the patient)

Diagnosis of Psychiatric Illness

Approximate Date of Illness Onset

Which of the following symptoms are present? (Please check all that apply)

- ☐ Anxiety
- ☐ Dementia or Senility
- ☐ Delusions
- ☐ Depression
- ☐ Paranoid Ideation
- ☐ Hallucinations
- ☐ Euphoria
- ☐ Suicidal Impulses
- ☐ Impairment of Judgement
- ☐ Poorly Controlled Anger
- ☐ Homicidal Impulses
- ☐ Poor Memory
- ☐ Bizarre Behavior
- ☐ Insomnia
- ☐ Intellectual Disability
- ☐ Other:

Please expand on any of the above, including approximate duration of illness, severity of illness, treatment, and prognosis.

	Start Date	Medication	Dosage
Current Medication and Dosage			
	Start Date	Medication	Dosage

Has the patient had any adverse reaction to medication, treatment, or therapy?

☐ Yes ☐ No If yes, please explain.

Does medication make the patient drowsy?

☐ Yes ☐ No

Is the patient capable of safely operating a commercial motor vehicle while taking the above prescribed medication(s)?

☐ Yes ☐ No If no, please explain.

Has the patient been hospitalized for the disorder?

☐ Yes ☐ No

If yes, please indicate when, where, and for how long.

Frequency of Therapy

Applicant's Name	Application Date

Section D: Psychological Evaluation (Continued)

Does the patient follow your medical and psychiatric recommendations?

☐ Yes ☐ No If no, please explain.

Do you believe the patient is capable of safely operating a commercial motor vehicle based on the patient's current medical condition, including medications?

☐ Yes ☐ No If no, please explain.

Do you recommend any driving restrictions based on medication or current medical condition of the patient?

☐ Yes ☐ No If yes, please explain.

Please provide other comments or recommended driving restrictions based on psychological condition of the patient.

Section E: Comments (The physician must fill out the section below before processing will occur)

How long has the patient been under your treatment?

Has the patient followed your medical recommendations?

☐ Yes ☐ No

Was the patient examined on this date?

☐ Yes ☐ No If no, specify the date of the most recent medical examination.

Does the patient take medications as prescribed?

☐ Yes ☐ No

Please explain any no answers to the above questions.

Was the patient referred to you by another doctor?

☐ Yes ☐ No

If yes, please indicate the name and address of the medical specialist who referred the patient to you.

What were the results of this consultation?

Any adverse reactions to medication, treatment, or therapy?

☐ Yes ☐ No If yes, please explain

Does medication make the patient drowsy?

☐ Yes ☐ No

Is the patient capable of safely operating a commercial motor vehicle while taking the above medication(s) or treatment(s)?

☐ Yes ☐ No If no, please explain.

Has the patient ever had occupational or physical therapy for the condition in question?

☐ Yes ☐ No

Do you recommend that the MSP request a statement of patient's psychological condition?

☐ Yes ☐ No

Applicant's Name	Application Date

Section E: Comments (Continued)

Do you recommend that the MSP request a statement of patient's visual acuity?

☐ Yes ☐ No

Do you recommend the MSP require periodic medical evaluation to monitor changes in patient's condition that may affect driving ability?

☐ Yes ☐ No If yes, how often?

Do you recommend any driving restrictions (times, trip lengths, trip radius, adaptive equipment, etc.)?

☐ Yes ☐ No If yes, please specify.

Do you recommend the patient's employer conduct an on-the-road driving performance evaluation for this driver at this time?

☐ Yes ☐ No If yes, how often?

If you wish to make additional comments, please use the space provided below or additional sheets, if necessary.

Section F: Physician's Certification (The physician must fill out the section below before processing will occur)

As of this date, I certify that the statements contained in this statement of examination are true to the best of my knowledge and belief.

Name (Print or Type)	☐ M.D. ☐ D.O. ☐ P.A. ☐ A.P.N.	Phone Number	
Address	City	State	ZIP Code
Professional License Number	Type of Practice or Medical Specialty		
Physician's Signature		Date	