Medical Examination Report
FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

1. DRIVER'S INFORMATION

Driver completes this section

Driver's Name (Last, First, Middle)	Social Security No.	Birthdate M / D / Y	Age	Sex ☐ M ☐ F	New Certification ☐ Recertification ☐ Follow-up ☐	Date of Exam

Address	City, State, Zip Code	Work Tel: ( ) Home Tel: ( )	Driver License No.	License Class ☐ A ☐ B ☐ C ☐ D ☐ Other	State of Issue

2. HEALTH HISTORY

Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes	No	
☐	☐	Any illness or injury in the last 5 years?
☐	☐	Head/Brain injuries, disorders or illnesses
☐	☐	Seizures, epilepsy ☐ medication_____
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack; other cardiovascular condition ☐ medication_____
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker) ☐ medication_____
☐	☐	High blood pressure
☐	☐	Muscular disease
☐	☐	Shortness of breath

Yes	No	
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin
☐	☐	Nervous or psychiatric disorders, e.g., severe depression medication_____
☐	☐	Loss of, or altered consciousness

Yes	No	
☐	☐	Fainting, dizziness
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Stroke or paralysis
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain
☐	☐	Regular, frequent alcohol use
☐	☐	Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

_____

_____

_____

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature_____ Date_____

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

_____

_____

_____

_____

DATE: ____/____/2015

I AUTHORIZE CHAMPLAIN MEDICAL ASSOCIATES TO RELEASE OF A COPY OF THE FOLLOWING MEDICAL RECORDS TO:

EMPLOYER: _____ _____

ADDRESS: _____

CITY _____

STATE: _____

ZIP: _____

__ PHYSICALS (INCLUDING DOTS)
__ PROGRESS NOTES
__ LAB/RADIOLOGY/ OTHER DIAGNOSTIC AND CARDIOLOGY RESULTS
__ CONSULTATIVE OR/DISCHARGE REPORTS
__ MED LISTS
__ ALL OF THE ABOVE

_____ _____ _____

Name of patient Signature

Date of Birth: _____

150 KENNEDY DRIVE
SOUTH BURLINGTON, VERMONT 05403
802–448–9370
802–448–1414(F)

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ Date: _____

Printed Name

_____

Signature

150 KENNEDY DRIVE
SOUTH BURLINGTON, VERMONT 05403
802–448–9370
802–448–1414(F)