

Medical Examination Report

FOR COMMERCIAL DRIVER FITNESS DETERMINATION

1. DRIVER'S INFORMATION		Driver completes this section.					
Driver's Name (Last, First, Middle)		Social Security No.	Birthdate M / D / Y	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> New certification <input type="checkbox"/> Recertification <input type="checkbox"/> Follow Up	Date of Exam
Address	City, State, Zip Code	Work Tel: () Home Tel: ()		Driver License No.		License Class <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> Other	State of Issue
2. HEALTH HISTORY		Driver completes this section, but medical examiner is encouraged to discuss with driver.					
Yes No <input type="checkbox"/> <input type="checkbox"/> Any illness or injury in last 5 years? <input type="checkbox"/> <input type="checkbox"/> Head/brain injuries, disorders or illnesses <input type="checkbox"/> <input type="checkbox"/> Seizures, epilepsy <input type="checkbox"/> medication _____ <input type="checkbox"/> <input type="checkbox"/> Eye disorders or injured vision (except corrective lenses) <input type="checkbox"/> <input type="checkbox"/> Ear disorders, loss of hearing or balance <input type="checkbox"/> <input type="checkbox"/> Heart disease or heart attack, other cardiovascular condition <input type="checkbox"/> medication _____ <input type="checkbox"/> <input type="checkbox"/> Heart surgery (valve replacement/bypass, angioplasty, pacemaker) <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> medication _____ <input type="checkbox"/> <input type="checkbox"/> Muscular disorder <input type="checkbox"/> <input type="checkbox"/> Shortness of breath		Yes No <input type="checkbox"/> <input type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis <input type="checkbox"/> <input type="checkbox"/> Kidney disease, dialysis <input type="checkbox"/> <input type="checkbox"/> Liver disease <input type="checkbox"/> <input type="checkbox"/> Digestive problems <input type="checkbox"/> <input type="checkbox"/> Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> diet <input type="checkbox"/> pills <input type="checkbox"/> insulin <input type="checkbox"/> <input type="checkbox"/> Nervous or psychiatric disorders, e.g., severe depression <input type="checkbox"/> Medication _____ <input type="checkbox"/> <input type="checkbox"/> Loss of, or altered consciousness		Yes No <input type="checkbox"/> <input type="checkbox"/> Fainting, dizziness <input type="checkbox"/> <input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring <input type="checkbox"/> <input type="checkbox"/> Stroke or paralysis <input type="checkbox"/> <input type="checkbox"/> Missing or impaired hand, arm, foot, leg, finger, toe <input type="checkbox"/> <input type="checkbox"/> Spinal injury or disease <input type="checkbox"/> <input type="checkbox"/> Chronic low back pain <input type="checkbox"/> <input type="checkbox"/> Regular, frequent alcohol use <input type="checkbox"/> <input type="checkbox"/> Narcotics 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. <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px;"></div>							

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.)

Medical Examination Report For Commercial Driver Fitness

H Kauffman



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web nov 1 2023 every year the odd semester 1st 3rd 5th are held in november december month and even semester 2nd 4th 6th are in april may month time table for diploma first semester 1st sem is ready here is official time table for exam 2023 the students who are studying under university they can download diploma time table

ankara yıldırım beyazıt Üniversitesi - Jul 04 2023

web 9 11 2021 tüm duyurular tÜrk dİLİ tdl101 5 aralık 2021 pazar sınav başlangıç saati 16 00 paylaş ankara yıldırım beyazıt Üniversitesi

diploma time table 2023 polytechnic semester exam date sheet - Aug 05 2023

web feb 1 2023 and technical education board of state released the diploma exam schedule semester wise odd even this time all boards are busy conducting odd semester 1st 3rd 5th sem exam and even semester 2nd 4th 6th sem examination polytechnic diploma exam organizes by the state board twice a year