

# Endocrinologist Annual Evaluation Checklist

## Federal Diabetes Exemption Program

### Driver Identifying Information

Name: \_\_\_\_\_  
                    First                                    MI                                    Last

Address: \_\_\_\_\_

DOB (MM/DD/YYYY): \_\_\_\_\_

**This applicant was granted an exemption from the Federal diabetes standard to operate a commercial motor vehicle (CMV) in interstate commerce. ANNUAL medical monitoring and reporting is a condition of the exemption from the diabetes standard of 49 CFR 391.41(b)(3).**

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

1.  I am board-certified in endocrinology.

I am board-eligible in endocrinology.

**If neither, do not continue your assessment. Applicants must be evaluated by an endocrinologist who is board-certified or board-eligible.**

2. Office telephone number: \_\_\_\_\_

3. Office fax number: \_\_\_\_\_

4. Date of examination (MM/DD/YYYY): \_\_\_\_\_

5. I have reviewed the patient's daily glucose logs (from his/her glucose monitoring device).  
 YES                       NO

6. I have compared monitoring dates to his/her driving log to ensure that the individual is checking glucose levels prior to operating a CMV as required.  
 YES                       NO

If **NO**, please comment: \_\_\_\_\_

7. I certify that this individual's glucose levels have been maintained in the range of 100 to 400 mg/dl while driving a CMV.  
 YES                       NO                       N/A

8. I certify that this individual continues to maintain a stable insulin regimen and that his/her glycosylated hemoglobin (A1C) result continues to reflect stable control of his/her insulin-treated diabetes mellitus (ITDM).  
 YES       NO

9. FMCSA defines a **severe hypoglycemic reaction** as one that results in:  
**Seizure, or loss of consciousness, or**  
**Requiring assistance of another person, or**  
**Period of impaired cognitive function that occurred without warning.**

In the last 12 months, while being treated for diabetes, has the patient had a severe hypoglycemic episode?       YES       NO

If yes, provide information on each hypoglycemic episode:  
Date(s):

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Include additional information about each episode including symptoms of hypoglycemic reaction, treatment, and suspected cause:

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Was the patient hospitalized?       YES       NO

If yes, provide brief summary of hospitalization:

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Has the patient's treatment regimen changed since the last hypoglycemic episode?  
 YES       NO

Briefly explain changes:

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10. Has the patient continued to receive education in the management of diabetes that includes diet, monitoring, recognition and treatment of hypoglycemia and hyperglycemia?  
 YES       NO

If yes, please provide last education date (MM/YYYY): \_\_\_\_\_

**Note: The applicant must participate in a diabetes education program at least annually to remain in the diabetes exemption program.**

11. I hereby certify that in my medical opinion, this applicant understands how to individually manage and monitor his/her diabetes mellitus.  YES  NO

12. Please describe the **progression** in diabetes complications/end organ diseases that have occurred in the **past year**: (*if none, write none*)

a) **Renal disease** \_\_\_\_\_  
\_\_\_\_\_

b) **Cardiovascular disease** \_\_\_\_\_  
\_\_\_\_\_

c) **Neurological disease** \_\_\_\_\_  
\_\_\_\_\_

Autonomic neuropathy  YES  NO  
(i.e, cardiovascular GI, GU)

Peripheral Neuropathy  YES  NO  
**(If YES, circle below)**  
Sensory  
Decreased sensation  
Loss of vibratory sense  
Loss of position sense

13. Has the patient **developed** any of the following complications within the past year (please check *yes* or *no*):

Renal Disease	Renal insufficiency	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Proteinuria	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Nephrotic Syndrome	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cardiovascular Disease	Coronary artery disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Hypertension	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Transient ischemic attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Peripheral vascular disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Neurological Disease	Autonomic neuropathy (i.e, cardiovascular GI, GU)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Peripheral Neuropathy (Circle below)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Sensory		
	Decreased sensation Loss of vibratory sense Loss of position sense		

Comments:

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14. List all medications including those taken related to the treatment of diabetes (if none, write none):

<b>Name of Medication</b>	<b>Dose</b>	<b>Reason for Taking the Medication</b>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

15. In your medical opinion, does any one of the listed medications have the potential to compromise the driver's ability to operate a CMV safely?

YES  NO

If yes, which medication(s): 

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16. In my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage their diabetes.  YES  NO

17. I hereby certify that in my medical opinion, the applicant is able to use insulin while safely operating a commercial motor vehicle (large truck or motor coach) in interstate commerce while using insulin.  YES  NO

18. **Please attach a copy of your office letterhead with your printed/typed name, signature, date, medical license number, and state of issue to this checklist.**

**Please send this completed annual endocrinology checklist to:**

**Diabetes Exemption Program  
1200 New Jersey Ave., SE  
Room W64-224  
Washington, DC 20590**

**If you have questions or need additional information, please call  
(703) 448-3094.**



5. Does the patient have diabetic retinopathy?       YES       NO

If yes:               Proliferative  
                                    O Stable      O Unstable  
                                     Nonproliferative  
                                    O Stable      O Unstable

Treatment: \_\_\_\_\_

Date diagnosed: \_\_\_\_\_

Surgery/procedures: \_\_\_\_\_

Requires recheck in \_\_\_\_ months

6. Does the patient have macular edema?

YES       NO  
                    O Stable      O Unstable

Requires recheck in \_\_\_\_ months

7. Does the patient have cataract(s)?

YES       NO  
                    O Stable      O Unstable

Requires recheck in \_\_\_\_ months

8. Does the patient have any other medical diagnosis related to vision?

YES       NO

If yes, what? \_\_\_\_\_

O Stable      O Unstable

Requires recheck in \_\_\_\_ months

**9. Please attach a copy of your office letterhead with your printed/typed name, signature, date, medical license number, and state of issue to this checklist.**

**Please send this completed annual vision checklist to:**

**Diabetes Exemption Program  
1200 New Jersey Ave., SE  
Room W64-224  
Washington, DC 20590**

**If you have questions or need additional information, please call  
(703) 448-3094.**