U.S. Department of Transportation			
Federal Motor Carrier Safety Administration			
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INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

	INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FO	ORM
Na	ame:	DOB:
Dr	river's License Number (if applicable):	State:
Fee has abided	his individual is being evaluated either to determine whether he/she meets the physical of deral Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicles recently experienced a severe hypoglycemic episode. A treating clinician should complete faility based on his/her knowledge of the individual's medical history. Completion of this form inician is making a medical certification decision to qualify the individual to drive a constermination as to whether the individual is physically qualified to drive a commercial motortified medical examiner on FMCSA's National Registry of Certified Medical Examiners.	cle or because the individual this form to the best of his/her does not imply that a treating inmercial motor vehicle. Any
	MCSA defines a treating clinician as a healthcare professional who manages, and prescribe e individual's diabetes mellitus as authorized by the healthcare professional's applicable St	
Ins	structions to the Individual:	
	Then you are being evaluated prior to a medical certification examination, the certified medic rm and begin the examination no later than 45 calendar days after a treating clinician signs to	
	Then you are being evaluated after a severe hypoglycemic episode, you must retain this for edical examiner at your next medical certification examination.	m and give it to the certified
Ins	sulin-Treated Diabetes Mellitus Diagnosis	
1.	Date insulin use began:	
Ble	ood Glucose Self-Monitoring Records	
2.	Has the individual maintained at least the preceding 3 months of ongoing blood glucose s being treated with insulin that are measured with an electronic glucometer that stores all r time of readings, and from which data can be electronically downloaded?	
3.	Has the individual provided at least the preceding 3 months of electronic self-monitoring with insulin from his/her glucometer to the treating clinician for review? YesNo	records while being treated

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OMB Control Number: 2126-0006 **Expiration Date:**

U.S. Department of Transportation **Federal Motor Carrier Safety Administration** Individual's Name: ____ If no, provide details: **Note:** The individual is not physically qualified to operate a commercial motor vehicle for up to the maximum 12-month period until he/she provides a treating clinician with at least the preceding 3 months of electronic blood glucose selfmonitoring records while being treated with insulin. At the certified medical examiner's discretion, the individual who does not possess at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with insulin may qualify to operate a commercial motor vehicle for up to but not more than 3 months. How many times per day is the individual testing his/her blood glucose? Is the individual compliant with blood glucose self-monitoring based on his/her specific treatment plan? ____Yes ____ No Comments (if necessary): _____ **Severe Hypoglycemic Episodes** Has the individual experienced any severe hypoglycemic episodes within the preceding 3 months? FMCSA defines a severe hypoglycemic episode as one that requires the assistance of others, or results in loss of consciousness, seizure, or coma. Yes No If yes, provide date(s) of occurrence, whether the cause has been addressed, and associated details (attach additional pages as needed): Hemoglobin A1C (HbA1C) Measurements Has the individual had HbA1C measured intermittently over the last 12 months, with the most recent measure within the preceding 3 months? ____Yes ____No If yes, attach the most recent result. **Diabetes Complications** Does the individual have signs of diabetic complications or target organ damage? This information will be used by the certified medical examiner in determining whether the listed conditions would impair the individual's ability to safely operate a commercial motor vehicle. a. Renal disease/renal insufficiency (e.g., diabetic nephropathy, proteinuria, nephrotic syndrome)? Yes No If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

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Indi	vidua	al's Name:
	b.	Diabetic cardiovascular disease (e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)? YesNo
		If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
	c.	Neurological disease/autonomic neuropathy (e.g., cardiovascular, gastrointestinal, genitourinary)? YesNo
		If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
	d.	Peripheral neuropathy (e.g., sensory loss, decreased sensation, loss of vibratory sense, loss of position sense)? YesNo
		If yes, provide the date of diagnosis, location, type of involvement, current treatment, and whether the condition is stable:
	e.	Lower limb (e.g., foot ulcers, amputated toes/foot, infection, gangrene)? YesNo
		If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
	f.	Other? (specify condition)YesNo
		If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
Pro	gre	essive Eye Diseases
9.	Da	te of last comprehensive eye examination:
10.	reti	s the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic inopathy? _YesNo
	If y	yes, provide date of diagnosis:

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Street Address

Federal Motor Carrier Safety Administration Individual's Name: ___ 11. Has the individual been diagnosed with any other progressive eye disease(s) (e.g., macular edema, cataracts, glaucoma)? ____Yes ____No If yes, specify the disease(s), provide the dates of diagnoses, current treatment, and whether the condition is stable: 12. Additional Comments (attach additional pages as needed) I attest that I am a treating clinician (as defined above), that this individual maintains a stable insulin regimen and proper control of his/her insulin-treated diabetes mellitus, and that the information provided is true and correct to the best of my knowledge. Date Printed Name and Medical Credential Signature Professional License Number and State Phone Number Email

City, State, Zip Code