

Bradley K. Harrison MD, FAAFP



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DEPARTMENT OF TRANSPORTATION (DOT) COMMERCIAL DRIVER FITNESS DETERMINATION
Controlled Substances

Patient Name _____

Controlled Substances: _____

DOT regulations Section 391.41 state "...a driver must have the perceptual skills to monitor a sometimes complex driving situation, the judgment skills to make quick decisions, when necessary, and the manipulative skills to control an oversize steering wheel, shift gears using a manual transmission, and maneuver a vehicle in crowded areas." The above medication(s) may adversely impact cerebral and/or cerebellar function.

Patient Consent for Release of Medical Information

I, _____ hereby authorize the release of all pertinent medical records and reports to Manhattan Primary Care for Commercial Driver Fitness Determination.

Patient Signature _____ DOB _____

Witness _____ Date _____

Statement of Personal Physician

I have read and understand the DOT regulations cited above. I verify the above-named individual is taking their prescribed controlled substances properly without concern of abuse. I verify that they have no side effects from the medication that would impair their ability to operate a motor vehicle.

Physician Name _____ Date _____

Physician Signature _____

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Fax (_____) _____

PLEASE SEND OR FAX THIS FORM TO THE ADDRESS OR FAX NUMBER INDICATED BELOW. THANK YOU FOR YOUR COOPERATION.

If you have any questions, please contact Manhattan Primary Care.