



DEPARTMENT OF TRANSPORTATION (DOT) COMMERCIAL DRIVER FITNESS DETERMINATION  
Obstructive Sleep Apnea

Patient Name \_\_\_\_\_

The above-named individual has presented for a Commercial Driver Fitness Determination in accordance with DOT regulations 49 CFR 391.41. The driver reports being diagnosed with sleep apnea. If their AHI >20 they will be denied a DOT card and referred back to their sleep specialist. The driver must provide a CDME compliance report is required showing use of CPAP for >4 hours nightly greater than 70% of days in the last month.

DOT guidelines: Part 391 of the Federal Motor Carrier Safety Regulations has been designed to protect both the health and safety of the driver and the general public. Respiratory Regulation 49 CRF 391.419(b)(5) of Federal Motor Carrier Safety Administration Medical Examiner Handbook updated 18May2014 states "A person is physically qualified to drive a commercial motor vehicle if that person — has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with his/her ability to control and drive a commercial motor vehicle safely." Driver is recommended to not be certified if they have hypoxemia at rest, untreated symptomatic OSA, narcolepsy, Primary (idiopathic) alveolar hypoventilation syndrome, Idiopathic central nervous system hypersomnolence, restless leg syndrome associated with excessive daytime sleepiness (EDS).

**Patient Consent for Release of Medical Information**

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

Patient Signature \_\_\_\_\_ DOB \_\_\_\_\_

**Statement of Personal Physician**

I have read and understand the DOT guidelines cited above. I attest that the patient has no hypoxemia at rest, untreated symptomatic OSA, narcolepsy, primary (idiopathic) alveolar hypoventilation syndrome, idiopathic central nervous system hypersomnolence, restless leg syndrome associated with EDS. I am enclosing appropriate copy of the sleep study. If patient is prescribed CPAP, the driver will need to provider CPAP Compliance Report showing use of CPAP for >4 hours nightly greater than 70% of days in the last month.

Physician Name \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Please send this form and supporting documents to the address or fax listed below. Thank you for your help in obtain certification for this driver. If you have any questions, please contact Manhattan Primary Care.