Bradley K. Harrison MD, FAAFP

Kyle E. Platz DO, FAAFP

DEPARTMENT OF TRANSPORTATION (DOT) COMMERCIAL DRIVER FITNESS DETERMINATION
Smoker Over Age 35.

Patient Name_____ Date_____

The above-named individual has presented for a Commercial Driver Fitness Determination in accordance with DOT regulations 49 CFR 391.41. During the examination it was noted that the individual is over the age of 35 and a current smoker. **The driver must have a spirometry performed to be cleared for DOT Certificate.**

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 smokers have a high incidence of COPD, yet individuals may have a significant reduction in lung function without symptoms. **Spirometry should be performed in all smokers over the age of 35 years.** If the forced expiratory volume in the first second of expiration (FEV1) is less than 65% of that predicted, arterial blood gas measurements should be evaluated.

Patient Consent for Release of Medical Information

I, _____hereby authorize the release of all medical records and reports, including diagnostic imaging, laboratory reports, or other pertinent studies 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, chronic respiratory failure, or history of continuing cough with cough syncope. I am enclosing appropriate documentation, if applicable, to support this statement. Please include a copy of the most recent pulmonary function testing showing FEV1 is > 65% predicted. If FEV1 is below 65%, please order and provide copy of atrial blood gas (ABG).

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.

Manhattan Primary Care
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