



US Department  
Of Transportation  
Federal Motor Carrier  
Safety Administration

1200 New Jersey Ave., SE  
Washington, DC 20590

Dear Applicant:

Thank you for your interest in the Federal Diabetes Exemption Program. The information in this letter and the accompanying materials need to be read carefully. The applicant is responsible for providing all required information. The following information is required to be submitted:

1. Applicant Information Checklist;
2. Signed copy of the Medical Examination Report (completed by the Medical Examiner);
3. Signed copy of the Medical Examiner's Certificate (completed by the Medical Examiner);
4. Endocrinologist Evaluation Checklist;
5. Vision Evaluation Checklist;
6. Copy of your driver's license and motor vehicle record.

### **How does the applicant apply for an exemption from the diabetes standard?**

#### **A. Medical Examiner**

The applicant must be examined by a medical examiner, as defined in 49 CFR 390.5. The examiner can be a physician, (MD, DO), advanced nurse practitioner, physician assistant, or chiropractor if allowed by their state regulations to certify drivers. This examination **STARTS** the exemption process. The applicant **MUST** take the Certifying Medical Examiner Evaluation letter to the appointment with the medical examiner for him/her to review prior to performing the examination. In addition, the applicant must bring a copy of his/her 5 year medical history to the examination for the medical examiner to review. The medical examiner will have copies of the United States Department of Transportation Medical Examination Report Form and the Medical Examiner's Certificate. The applicant must meet all medical standards and guidelines, other than diabetes, in accordance with 49 CFR 391.41 (b) (1-13).

Other than the use of insulin to treat their diabetes, any other medical problem or condition that prevents the applicant from being certified by the medical examiner must be corrected **BEFORE** the rest of this application is completed. Therefore, the endocrinologist and vision evaluations **SHOULD NOT** be completed until the medical examiner certifies the applicant. The applicant must submit copies of the completed medical examination report and medical examiner's certificate. The certificate should indicate that the driver is certified **ONLY IF** the driver has a diabetes exemption. The certificate is not valid until the insulin exemption is obtained from the Federal Motor Carrier Safety Administration (FMCSA).

## **B. Endocrinologist Evaluation Checklist**

The applicant must be examined by a physician who is a board-certified or board-eligible endocrinologist. The applicant must take the Endocrinologist Evaluation Checklist and glucose logs to the appointment. The endocrinologist must complete all parts of the checklist. The applicant must submit the endocrinologist's signed letterhead, a completed checklist, and any additional reports outlined in the checklist to the exemption program.

## **C. Vision Evaluation Checklist**

The applicant must have a vision examination by an ophthalmologist or optometrist. An applicant with **diabetic retinopathy MUST be evaluated by an ophthalmologist**. The applicant must take the Vision Evaluation Checklist to the appointment. The ophthalmologist or optometrist must complete all parts of the checklist. The applicant must submit the optometrist/ophthalmologist's signed letterhead and a completed checklist to the exemption program.

Please note that both the Endocrinologist and Vision medical evaluations are only valid for 6 months from the date performed. The medical examiner's evaluation is valid for 1 year from the date performed. Applicants will be required to submit a new examination for any of the aforementioned examinations if they expire during the application process.

## **D. Additional Applicant Information**

The applicant must provide a completed Applicant Information Checklist, a readable photocopy of both sides of the driver's license, and a current motor vehicle record.

Additional medical information may be required, based on review of the information submitted. Prior to submitting the application, please review all information and make sure that each checklist is **completely filled out and that all required information is included**. Application review will be delayed if the information submitted is not current or if it is incomplete. Mail all information to:

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

The application may be faxed to 703-448-3077. However, original documents **must** be mailed to the above address.

## **What Happens After a Completed Application Is Submitted?**

The FMCSA will review the application and notify the applicant if additional information is required or missing. Please note, as stated above, that additional medical information may be required. Once the application is complete, the FMCSA will determine applicant eligibility for this program.

If the applicant is eligible for an exemption, the FMCSA is required to publish the applicant request for exemption in the Federal Register twice; this includes a 30 day period for public comment and notification of the Agency's final decision. The notice discloses the applicant's full name, age, basic information related to the applicant's insulin use to control diabetes, and the type of driving license held; however, the notice does not include any detailed personal information, such as the applicant's address, employer, medical records, or driver's license number.

If granted, the Federal exemption is valid for CMV operation within the United States and does not exempt the applicant from foreign requirements, such as Canada and Mexico.

**If the Applicant Does Not Meet Eligibility Criteria**

If the FMCSA determines that the applicant does not meet program eligibility criteria, a decision letter will be mailed directly to the applicant outlining the reason that the Agency is unable to grant the exemption from the Federal diabetes standard.

**How Long Does the Process Take?**

The FMCSA is required to complete the application process within 180 days from the date all required information is submitted by the applicant.

**What Is Required of the Driver After an Exemption Is Granted?**

The exemption certificate and requirements are sent to the exempted applicant by certified mail. The FMCSA can issue an exemption for a maximum of 2 years. Quarterly and annual medical monitoring and reporting are conditions of the exemption from the Federal diabetes standard of 49 CFR 391.41(b)(3). The driver will receive the necessary forms from the FMCSA and will be responsible for compliance. Additionally, the driver is required to reapply for renewal every two years, and, as with monitoring, the responsibility of reapplication rests with the driver. The driver must have yearly medical re-certification examinations.

If you have questions related to the application process outlined in this document, please call 703-448-3094.

Sincerely yours,



Elaine M. Papp, RN MSN COHN-S CM  
Division Chief, Medical Programs

Enclosures

# Applicant Checklist

## 1. Driver Information

Name (First, Middle Initial, Last): \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Mailing Address, if different from above:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mobile phone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Sex (check one):  Male  Female

Date of birth (MM/DD/YYYY): \_\_\_\_\_

Social Security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## 2. Current Employment

Employer's name (If applicable): \_\_\_\_\_

Employer's address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Employer's telephone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Do you currently drive for this employer? (Check one):  YES  NO

### 3. Statement of Qualification

Prior to signing this statement, please review the Regulatory Criteria on Physical Qualifications for Commercial Drivers attached to the Endocrinologist Medical Evaluation Checklist.

Note: “otherwise qualified” or “hold a valid medical exemption” means that you meet the physical qualification standards to drive a Commercial Motor Vehicle (CMV) (except for diabetes) or that you have an exemption or a skill performance evaluation certificate.

By signing below, I hereby certify that the following statement is true: “I acknowledge that I must be otherwise qualified under 49 CFR 391.41(b)(1-13) or hold a valid medical exemption before I can legally operate a CMV in interstate commerce.”

Signature: \_\_\_\_\_

I intend to drive a CMV in:      Intrastate commerce only

Interstate commerce only

Interstate Commerce is trade, traffic, or transportation involving the crossing of a State boundary. Either the vehicle, its passengers, or cargo must cross a State boundary, or there must be the intent to cross a State boundary to be considered an interstate carrier.

Intrastate Commerce is trade, traffic, or transportation within a single State.

Do you have any waivers, exemptions, or Skill Performance Evaluation certificates? (check one)

YES       NO

If yes, list each, including date of issue, date of expiration, and identification number.

Name	Issue Date	Expiration Date	ID#
_____			
_____			
_____			

### 4. Driver License and Motor Vehicle Record

Please attach a readable copy of **both sides** of your current **VALID** driver’s license. You must include your driving record, furnished by an official state agency on its letterhead, bearing the state seal or official stamp. ***No other documentation will be accepted*** This request is to verify that you have a valid license and will not be used for any other purpose.

# **CERTIFYING MEDICAL EXAMINER EVALUATION GUIDELINES**

## **FEDERAL DIABETES EXEMPTION PROGRAM**

The applicant is applying for a Federal diabetes exemption to allow insulin use while operating a commercial motor vehicle (large truck or bus) in interstate commerce. Effective July 15, 2007, the driver is required to be examined by a medical examiner as part of the application process. A medical examiner is defined as an advanced practice nurse, doctor of chiropractic, doctor of osteopathy, medical doctor, or physician assistant who is licensed in their state to perform these examinations. This change will assist the Agency in determining that the individual is qualified for all medical standards, other than diabetes, in accordance with 49 CFR 391.41(b); expedite the application process; and make the process consistent with other medical exemption and certificate programs, including the Skill Performance Evaluation program.

This examination begins the exemption process. The certifying medical examiner must review the applicant's 5 year medical history and provide the applicant with a completed U.S. Department of Transportation medical examination report and medical examiner's certificate. The applicant is responsible to submit copies of these forms with their application. The form and certificate are not valid until Federal Motor Carrier Safety Administration (FMCSA) has issued an insulin exemption. Any other medical problem or condition that prevents being certified by the medical examiner must be corrected **BEFORE** the rest of this application is completed.

**IT IS THE EXAMINER'S RESPONSIBILITY TO DETERMINE IF THE APPLICANT MEETS ALL MEDICAL STANDARDS AND GUIDELINES, OTHER THAN DIABETES, IN ACCORDANCE WITH 49 CFR 391.41 (B) (1-13). IF THE APPLICANT PASSES THE CERTIFICATION EXCEPT FOR USING INSULIN:**

***Check the following on the Medical Examination Report:***

- meets standards but periodic evaluation required due to **"insulin use"** driver qualified only for (check the 1 year box)
- accompanied by a **"Federal diabetes"** waiver/exemption

***Check the following on the Medical Examiner's Certificate:***

- accompanied by a **"Federal diabetes"** waiver/exemption
- Medical examination expiration date should be one year from the date of examination.

**The applicant is required to submit copies of the Medical Examination Report and Medical Examiner's Certificate along with the endocrinologist and the ophthalmologist/optometrist evaluation checklists, to be reviewed by FMCSA for the determination of qualification for the Federal diabetes exemption.**

If you have questions, please call 703-448-3094. When calling, please leave a message on our automated system for the Federal diabetes exemption program. A program representative will return your call.

**Please print and sign your name below and return this to the applicant:**

Medical Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Medical Examiner's Name (please print): \_\_\_\_\_

# Endocrinologist Evaluation Checklist

## Federal Diabetes Exemption Program

### Driver Identifying Information

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

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

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

**This applicant is applying for a Federal diabetes exemption to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in interstate commerce. Part of the application process is an evaluation by a board-certified or board-eligible Endocrinologist to determine if the individual has any medical problem related to diabetes that might impair safe driving.**

**The applicant's examination by an Endocrinologist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.**

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 most recent examination (MM/DD/YYYY): \_\_\_\_\_
5. I am familiar with the patient's medical history for the past 5 years through a records review, treating the patient or consultation with the treating physician.  
 YES                       NO

**A review of the applicant's 5-year medical history is required. If the history is not available, please state the reason.**

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6. Date of initial diagnosis of diabetes mellitus: \_\_\_\_\_

Treatment for diabetes mellitus prior to insulin use:

None       Diet       Oral agent

7. Insulin Usage:

Date insulin use began: \_\_\_\_\_

Type of insulin(s) and current dosage now used: \_\_\_\_\_

Length of time on current dose: \_\_\_\_\_

Is the applicant compliant with his/her insulin regimen?     YES       NO

If patient uses insulin pump, current average daily dose: \_\_\_\_\_

8. 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 5 years, while being treated for diabetes, has the patient had recurrent (2 or more) severe hypoglycemic episodes?     YES       NO

In the last 12 months, while being treated for diabetes, has the patient had a severe hypoglycemic episode?     YES       NO **(If no proceed to #9 below)**

If yes, provide information on each hypoglycemic episode:

Date(s):

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the patient hospitalized?     YES       NO

If yes, provide brief summary of hospitalization:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the patient's treatment regimen changed since the last hypoglycemic episode?

YES       NO

Briefly explain changes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Additional Information or History (If none, write *none*):



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

Name of Medication	Dose	Reason for Taking the Medication

11. 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): \_\_\_\_\_

12. Associated Medical Conditions (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 <b>(Circle one below)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Sensory		
	Decreased sensation		
	Loss of vibratory sense		
	Loss of position sense		

**If the applicant has been or is currently being treated for any of the above medical conditions, provide relevant additional information** (consultation notes, special studies, follow-up reports, and hospital records).

13. Stable Insulin Regimen/Glucose Measurements:

A. Background and criteria:

The driver should have stable control and no risk of hypoglycemia and hyperglycemia while operating a CMV.

**30 day requirement: An individual diagnosed with diabetes mellitus who had been previously treated with oral medication, and who now requires insulin, should have at least a 1-month period on insulin to establish stable control.**

**60 day requirement: An individual newly diagnosed with diabetes mellitus, who is now starting insulin, should have at least a 2-month period on insulin to establish stable control.**

B. Glucose Measurements:

A CMV driver **should not have large fluctuations in blood glucose levels. The determination of a patient's stable control is left to the treating endocrinologist.**

a. I have reviewed the patient's daily glucose monitoring logs while using insulin.

YES       NO

b. Does the patient have any large fluctuations that may impact safe driving?

YES       NO

14. Since beginning insulin use, has the patient received 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 apply for and remain in the diabetes exemption program.**

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

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 safely operate a commercial motor vehicle (large truck or motor coach) in interstate commerce while using insulin.       YES       NO

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

## Vision Evaluation Checklist

### Federal Diabetes Exemption Program

#### Driver Identifying Information

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

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

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

**This applicant is applying for a Federal diabetes exemption to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in interstate commerce. Part of the application process is an eye examination by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving.**

**NOTE: If the applicant has retinopathy, an ophthalmologist examination is required.**

**The applicant’s examination by an ophthalmologist or an optometrist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.**

**PLEASE CHECK / FILL IN REQUESTED INFORMATION.**

1.       I am an ophthalmologist                       I am an optometrist

Office Telephone number: \_\_\_\_\_ Office Fax number: \_\_\_\_\_

2.      Date of most recent examination: \_\_\_\_\_ (MM/DD/YYYY)

3.      Distant visual acuity (**please provide both if applicable**):

UNCORRECTED                       CORRECTED  
Glasses  
Contact Lens

Right eye:    20/ _____	Right eye:    20/ _____
Left eye:    20/ _____	Left eye:    20/ _____

4.      Field of vision (FOV)\*:  
Please record the interpreted results in **degrees** of horizontal field of vision for each eye.  
The terms “normal” or “full” are not acceptable responses.

Right eye: \_\_\_\_\_ degrees  
Left eye: \_\_\_\_\_ degrees  
Test used to determine: \_\_\_\_\_

**\*Note:** If the patient has received laser treatment, and in your medical opinion you believe the patient's FOV is compromised, FMCSA recommends formal perimetry to determine if the driver meets the FOV standard.

5. Color Vision:  
Is the patient able to identify correctly the standard red, green, and amber traffic control signal colors?  YES  NO

**Note:** If color testing results are inconclusive, it is discretionary whether to administer a controlled test using an actual traffic signal to determine the individual's ability to recognize red, green, and amber.

**An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).**

6. Does the patient have diabetic retinopathy?  YES  NO

If yes:  Proliferative  
                     Stable       Unstable  
 Nonproliferative  
                     Stable       Unstable

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

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

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

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

7. Does the patient have macular edema?  
 YES  NO

8. Does the patient have cataract(s)?  
 YES  NO

9. Does the patient have any other medical diagnosis related to vision?  
 YES  NO

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

10. If yes to any of the conditions listed above, are any unstable?  
 YES  NO

If yes, which condition(s)? \_\_\_\_\_

11. In your medical opinion, is monitoring required more often than annually?  
 YES  NO

If yes, how often? \_\_\_\_\_

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