Beyond Wellness

Chiropractic Center

Insulin-treated diabetes assessment, MCSA-5870

For your DOT visit at Beyond Wellness

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Charlotte, NC 28269
Office: 704-461-1836
Return fax: 704-246-5156

Return instructions

Bring the requested completed form to your DOT visit, or call the office to confirm the approved return method before sending medical records. Keep this cover sheet with the form so the return office is clear.

Your clinician who manages and prescribes insulin completes this assessment when the insulin-treated diabetes standard applies.

Timing: the examiner must receive the completed form and begin the examination within 45 calendar days after the appropriate clinician signs it. Plan that provider visit around your DOT appointment.

Complete only the sections assigned to you. Clinical findings, signatures, dates and qualification decisions have not been completed by the clinic in this packet.

https://beyondwellnesscc.com/dot-physical-charlotte/diabetes-records/

MCSA-5870

OMB No.: 2126-0006
Expiration Date: 03/31/2028

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

Individual's Name: _____

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 8 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Medical Programs Division, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

Name: _____ **DOB:** _____

Driver's License Number *(if applicable)*: _____ **State:** _____

This individual is being evaluated either to determine whether he/she meets the physical qualification standards of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle or because the individual has recently experienced a severe hypoglycemic episode. A treating clinician should complete this form to the best of his/her ability based on his/her knowledge of the individual's medical history. Completion of this form does not imply that a treating clinician is making a medical certification decision to qualify the individual to drive a commercial motor vehicle. Any determination as to whether the individual is physically qualified to drive a commercial motor vehicle will be made by a certified medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines a treating clinician as a healthcare professional who manages, and prescribes insulin for, treatment of the individual's diabetes mellitus as authorized by the healthcare professional's applicable State licensing authority.

Instructions to the Individual:

When you are being evaluated prior to a medical certification examination, the certified medical examiner must receive this form and begin the examination no later than 45 calendar days after a treating clinician signs this form.

When you are being evaluated after a severe hypoglycemic episode, you must retain this form and give it to the certified medical examiner at your next medical certification examination.

Insulin-Treated Diabetes Mellitus Diagnosis

1. Date insulin use began: _____

Blood Glucose Self-Monitoring Records

2. Has the individual maintained at least the preceding 3 months of ongoing blood glucose self-monitoring records while being treated with insulin that are measured with an electronic glucometer that stores all readings, records the date and time of readings, and from which data can be electronically downloaded?

   ☐ Yes ☐ No

3. Has the individual provided at least the preceding 3 months of electronic self-monitoring records while being treated with insulin from his/her glucometer to the treating clinician for review?

   ☐ Yes ☐ No

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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 self-monitoring 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.*

4. How many times per day is the individual testing his/her blood glucose? _____

5. Is the individual compliant with blood glucose self-monitoring based on his/her specific treatment plan?

☐ Yes ☐ No

Comments, if necessary:

_____

Severe Hypoglycemic Episodes

6. 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):

_____ ATTACH FILE

_____

Hemoglobin A1C (HbA1C) Measurements

7. 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. ATTACH FILE

Diabetes Complications

8. 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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b. Diabetic cardiovascular disease (e.g., coronary artery disease, hypertension, transient ischemic attack, stroke, peripheral vascular disease)?

☐ Yes ☐ No

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)?

☐ Yes ☐ No

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)?

☐ Yes ☐ No

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)?

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

f. Other? *(specify condition)*: _____

☐ Yes ☐ No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

_____

_____

Progressive Eye Diseases

9. Date of last comprehensive eye examination: _____

10. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?

☐ Yes ☐ No

If yes, provide date of diagnosis: _____

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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)*

_____

_____

_____

_____

ATTACH FILE

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*

_____ _____
Street Address *City, State, Zip Code*

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