EASTERN MEDICAL SUPPORT

Your Health & Safety Source

PATIENT NAME_____ **DATE** _____

PATIENT ADDRESS_____ **CITY**_____ **ZIP CODE**_____

DOB_____ **PHONE**_____

COMPANY NAME_____

MEDICAL SURVELLANCE
19A PHYSICAL
DOT PHYSICAL
FIRE DEPT PHYSICAL
PHYSICAL
POLICE/ROAD PATROL PHYSICAL
MASK FIT/CLEARANCE
RESPIRATOR WRITTEN OPNION
SCBA FIT TEST
AUDIOGRAM
PFT
EKG
VISUAL ACUITY
PULSE OXIMETRY
ASBESTOS
HAZMAT

TESTING
BLOOD COLLECTION
HAIR/FINGERNAIL
BREATH ETOH
DOT/NIDA COLLECT & TEST
SAP5 COLLECT & TEST
SAP 10 COLLECT & TEST

IMMUNIZATIONS
TETANUS
PPD
HEP B #_____
HEP A
MMR
FLU/PNEUMONIA

LABORATORY
CBC
CHOLESTEROL
HEPATITIS SCREEN
HIV SCREEN
LIPID PANEL
RUBELLA TITER
RUBEOLA TITER
HEP B TITER
ZPP
SERUM LEAD
CHEST X RAY 1 VIEW/2 VIEW
OTHER _____
OTHER _____
URINALYSIS

WORKERS COMPENSATION

NEW PATIENT
99201 E/M LEVEL 1
99202 E/M LEVEL 2
99203 E/M LEVEL 3
99204 E/M LEVEL 4
99205 E/M LEVEL5

ESTABLISHED PATIENT
99211 E/M LEVEL 1
99212 E/M LEVEL 2
99213 E/M LEVEL 3
99214 E/M LEVEL 4
99215 E/M LEVEL 5

COUNSELING
99401 15 MINS
99402 30 MINS
99403 45 MINS
99404 60 MINS

DIAGNOSIS
BACKACHE
CARPLE TUNNEL SYNDROME
CELLULITIS
CERVICAL STRAIN
CONTACT DERMATITIS
DERMATITIS
HEADACHE
LUMBAR STRAIN
MUSCLE SPASMS
RASH
SCIATICA
SYNCOPE
VERTIGO
RADICULOPATHY
AVULSION
BURN/TYPE
CONTUSION
DEGENERATIVE
JOINT DISEASE
LACERATION
FRACTURE
SPRAIN/STRAIN
TENDONITIS

PROCEDURE_____
B/P CHECK
DRESSING CHG
EAR IRRIGATION
EYE IRRIGATION
FLOUROSCENE STAIN
SUTURE PLACEMENT
SUTURE REMOVAL
SM JOINT BURSA INJ
INTERMEDIATE JOINT INJ
MAJOR JOINT INJ

SITE

DIAGNOSIS

MEDS GIVEN

TESTS ORDERED

_____

SIGNATURE – MEDICAL PROVIDER

Eastern Medical Support
2 Guy Park Avenue
Amsterdam, NY 12010
Ph: (518) 843-6860
Fx: (518) 684-0156

Eastern Medical Support
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Gloversville, NY 12078
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WWW.EASTERNMEDICALSUPPORT.COM

EASTERN MEDICAL SUPPORT

Your Health & Safety Source

CONSENT FOR TREATMENT & RELEASE OF INFORMATION

I consent to receiving treatment and/or a physical examination to be performed by the physician, nurse practitioner and/or professional staff at the Occupational Health Center. I permit the physician, nurse practitioner, and or staff of Eastern Medical Support, LLC to treat me in ways they judge beneficial to me or have been requested by my employer or prospective employer. I understand that this care may include tests, physical examinations, immunizations and the drawing of my blood.

I further consent that the medical information and results of such test or treatment that is related to my job / job functions may be released to the guarantor (Example: The company authorizing and paying for the medical services or their agents).

PERMISSION TO CONTACT YOUR MEDICAL PROVDER(S)
&
PRIVACY STATEMENT / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

During the completion of your medical exam, significant findings may be identified which could have an impact on the performance of your work related duties. Further information from your medical provider(s) may be necessary to clear you for the employment or volunteer position you currently seek.

Please sign below if you agree to allow us to contact your medical provider(s) regarding significant medical findings, and / or additional information to clear you for your duties.

Furthermore, you also acknowledge that you have read and understand Eastern Medical Support's HIPAA policy regarding the use of disclosure of protected health information, which is made is accordance with Federal Law (electronic version is available at www.easternmedicalsupport.com/resources.php).

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

The patient is unable to give consent because: _____

Signature: _____ Date: _____

Relationship: _____

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

Medical Examination Report Form
(for Commercial Driver Medical Certification)

PRIVACY ACT STATEMENT: ***This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.***

AUTHORITY: Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

MEDICAL RECORD #
_____
(or sticker)

PURPOSE: To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State.

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].

ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses" (available at http://www.dot.gov/privacy/privacyactnotices).

ACKNOWLEDGMENT: ***I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.***

Driver's Signature: _____ Date: _____

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____ Gender: ○ M ○ F

E-mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ○ Yes ○ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ **Yes** ○ **No** ○ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ **Yes** ○ **No** ○ **Not Sure**

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures, epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

TESTING

Pulse rate: _____ Pulse rhythm regular: ○ Yes ○ No Height: __ *feet* __ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading (optional)		

Other testing if indicated

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/____	20/____	Right Eye: ____ degrees
Left Eye:	20/____	20/____	Left Eye: ____ degrees
Both Eyes:	20/____	20/____	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

*Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ○ Right Ear ○ Left Ear ○ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	_____	_____

OR

Audiometric Test Results

	Right Ear			Left Ear		
	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
	_____	_____	_____	_____	_____	_____

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Genito-urinary system including hernias	○	○
3. Eyes	○	○	10. Back/Spine	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Neurological system including reflexes	○	○
6. Cardiovascular	○	○	13. Gait	○	○
7. Lungs/chest	○	○	14. Vascular system	○	○

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

○ Does not meet standards *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*

○ Determination pending *(specify reason)*: _____

☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____

☐ Medical Examination Report amended *(specify reason)*: _____

(if amended) Medical Examiner's Signature: _____ Date: _____

○ Incomplete examination *(specify reason)*: _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):

○ Does not meet standards in 49 CFR 391.41 with any applicable State variances *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41 with any applicable State variances

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements *(State)*

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

EASTERN MEDICAL SUPPORT

Your Health & Safety Source

SLEEP DISORDER INSTRUCTIONS

Sleep Disorders can present a major problem for driving safely. There is a four-fold chance of a motor vehicle accident in people who have sleep disorders. Lack of proper amount of sleep can lead to difficulty with response time and alertness and can lead to falling asleep while driving.

- If you have difficulty with drowsiness during your work hours, it is extremely important that you not attempt to drive.
- If your drowsiness is due to several days of loss of sleep secondary to an illness, injury, or mental stress. We strongly recommend that you see your primary doctor and avoid driving until a healthy sleep pattern has returned.
- If you are having symptoms of work time drowsiness for unknown reasons, we strongly recommend that you remove yourself from driving. You should discuss these symptoms with your primary care physician and have a sleep evaluation performed.
- If you are receiving treatment for a sleep disorder such as obstructive sleep apnea, you must follow the prescribed treatments. If you are on CPAP for sleep apnea, you will need yearly examinations by the sleep specialist to give clearance for recertification for state or federal controlled commercial licenses. If you skip a night using the CPAP, you are at risk of having an episode of sleep during work. You must remove yourself from driving until the day after using the CPAP. The CPAP machines have memory chips in them, which identify what nights they have been used. Evaluations of the memory chips on a random basis will be part of the yearly evaluations.

I, the undersigned, have read and understand the importance of following the instructions indicated above.

_____ _____

Signature Date

OCCUPATIONAL MEDICINE - DOT

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EASTERN MEDICAL SUPPORT

Your Health & Safety Source

2 Guy Park Avenue, Lower Level
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Phone: 518.843.6860
Fax: 518.684.0156

Authorization for Release of Confidential Medical Information

Patient Name: _____ Date: _____

Address: _____

Phone: _____ Date of Birth: _____

I, the undersigned, hereby authorize and request **Eastern Medical Support, LLC** to release all confidential medical information regarding my condition for the period of the time specified below. This authorization includes physical forms, progress notes, consultation, laboratory tests, x-ray reports, diagnostic studies, telephone messages, medication and health flow maintenance flow sheets, immunization records, and discharge summaries.

Disclosure information to:

_____
Employer / Facility / Physician Name

_____
Address / Phone number

_____
Reason for this release of information

_____
Nature of condition (be as specific as possible)

***Date of Service*: From: _____ To: _____**

I understand that I can decide to at any time to cancel this release in writing but, that letter will not apply to records already sent.

Time during which release is authorized (*Please check one*):

◯ ***1 year*** or
◯ From: _____ To: _____

_____ _____
Signature **Date**

_____
Relationship if other than patient