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

NON-INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

Driver Name: _____ **DOB:** _____

The individual named above is being evaluated to determine whether the individual meets the physical qualification standards of the Federal Motor Carrier Safety Administration to operate a commercial motor vehicle in interstate commerce. During the medical evaluation, it was determined this individual has a diagnosis of non-insulin-treated diabetes mellitus. Although there is not a standard specific to non-insulin-treated diabetes mellitus, this information will be used by the certifying medical examiner to evaluate any diabetes-related complications and/or target organ damage and to determine whether the individual's physical condition is adequate to enable the individual to operate a commercial motor vehicle safely. The final determination as to whether the individual listed in this form is physically qualified to drive a commercial motor vehicle will be made by the certifying medical examiner.

As the certifying medical examiner, I request that you review and complete this form, and return it to me via the individual, or at the mailing address, email address, or fax number specified below.

Printed Name of Certified Medical Examiner	*Signature of Certified Medical Examiner*
Date	*Email*
Phone Number	*Fax Number*
Street Address	*City, State, Zip Code*

Driver Name: _____

Non-Insulin-Treated Diabetes Mellitus Diagnosis

1. Date of diabetes mellitus diagnosis: _____
2. Medications - List all diabetes-related medications, dosage, and date treatment initiated *(attach additional pages if necessary)*

   Medication: _____ Dosage: _____ Date started: _____

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ATTACH FILE

Blood Glucose Self-Monitoring

3. How many times per day is the individual testing blood glucose levels? _____
4. Is the individual compliant with glucose monitoring based on the individualized diabetes treatment plan?

   ☐ Yes ☐ No

Diabetes Management and Control

5. Has the individual been on a stable individualized diabetes treatment plan with good glucose control?

   ☐ Yes ☐ No

   If no, explain why not *(attach additional pages if necessary)*:

   _____

   _____

ATTACH FILE

6. Has the individual experienced any recent severe hypoglycemic episodes *(e.g., episodes requiring the assistance of others or resulting in loss of consciousness, seizure, or coma)*?

   ☐ Yes ☐ No

   If yes, provide date(s) of occurrence and associated details *(attach additional pages if necessary)*:

   _____

   _____

ATTACH FILE

7. Has the individual experienced any recent significant hyperglycemic episodes *(e.g., diabetic ketoacidosis and diabetic hyperglycemic hyperosmolar syndrome)*?

   ☐ Yes ☐ No

   If yes, provide date(s) of occurrence and associated details *(attach additional pages if necessary)*:

   _____

   _____

ATTACH FILE

Driver Name: _____

Hemoglobin A1c (HbA1c) Measurements

8. Has the individual had HbA1c measured intermittently over the last 12 months?

☐ Yes ☐ No

If yes, attach the most recent result. ATTACH FILE

Diabetes Complications

9. Does the individual have signs of diabetes complications or target organ damage?

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:

_____

_____

b. 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, 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?

☐ Yes ☐ No

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

_____

_____

Diabetic Retinopathy

10. Date of last eye examination: _____

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

☐ Yes ☐ No

If yes, provide date of diagnosis: _____

Comments *(if necessary)*:

_____

_____

_____

I am the treating healthcare provider for the above individual.

☐ Yes ☐ No

Comments** (if necessary)**:

_____

_____

_____

Printed Name of Treating Healthcare Provider	*Signature of Treating Healthcare Provider*
Professional License Number and State	*Date*
Phone Number	*Email*
Street Address	*City, State, Zip Code*