Franciscan WORKING Well

Dear CDL Candidate:

Thank you for partnering with Franciscan Health for your CDL Physical. It's important to understand how to prepare for your physical – in advance – for the best experience.

Please consider the following action items ***before you come for your exam***:

- ☐ Gather any test results and letters from your doctor related to your CDL Physical. Use the enclosed form(s) for your convenience. Forms are required for:
    - ☐ Blood pressure conditions
    - ☐ Diabetes
    - ☐ Sleep apnea – Use the enclosed Obstructive Sleep Apnea Questionnaire to see if you are at risk for Sleep Apnea. If you score 3 or above, contact your doctor for further directions. You may need a sleep study in order to obtain a "long term" CDL (1-2 year) license.
    - ☐ Heart conditions
    - ☐ Respiratory conditions
    - ☐ Vision / Hearing conditions
- ☐ On the day of your exam, bring the following:
    - ☐ Driver's license / picture identification for any learner's permit
    - ☐ Glasses or contact lenses (*If you have them, bring them!*)
    - ☐ Hearing aids (*If you have them, bring them!*)
    - ☐ List of medications *(Use the reverse side of the DOT Tip Sheet in packet.)*
    - ☐ Test results and letters from your doctor(s).
- ☐ If your company is paying for your physical, bring their Authorization Form. One is included in this packet for your convenience.

We want your experience to be successful with the best possible outcome. Please contact your Franciscan WorkingWell location with any additional questions:

Respectfully,

Franciscan WorkingWell Client Services

DOT PHYSICAL TIP SHEET

Federal law requires that commercial motor vehicle drivers (CMVs) have routine physical examinations. Franciscan WorkingWell Department of Transportation (DOT) medical examiners are specially trained in understanding these regulations and preventing drivers from being inappropriately disqualified.

Follow these tips to facilitate your exam.

PRIOR TO YOUR EXAMINATION

- **List all medications you regularly take** (prescription and over-the-counter). Please use the reverse side of this flyer to list your medications.
- **Gather any test results and/or letters from your doctor(s) that may be needed during the exam.** (Examples include blood tests, stress test results, clearance from a cardiologist.)
  - Examples of common health conditions requiring additional documentation:

    High blood pressure
    - List of medications
    - Must be 140/90 or less to qualify for a valid DOT certificate

    Diabetes
    - List of medications
    - Recent blood test (hemoglobin A1C)

    Sleep apnea
    - Copy of most recent sleep study or CPAP compliance report

    Heart conditions
    - Written clearance from cardiologist
    - Results of recent stress test with ejection fraction
- **Continue to take your medications as directed by your doctor.**

ON THE DAY OF THE EXAM

- **Bring the following:**
  - Driver's license
  - Glasses/contact lenses (if needed)
  - Hearing aids (if needed)
  - List of medications (documentation sheet on the reverse side of this flyer)
  - Test results and/or letters from your doctors
- **The exam will include:**
  - Health history, medications and test results/ letters review
  - Urine test
  - Hearing test
  - Vision test
  - Physical exam
  - Others test(s) as needed
- **The examiner will determine the expiration date of your certificate:**
  - Maximum length is two years from date of exam
  - Certain medical conditions may require more frequent monitoring and/or a shorter duration of the medical certificate

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Please list current medications

	Medication	Dose (e.g., 10mg, 20mg)	Frequency (e.g., twice a day)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

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OBSTRUCTIVE SLEEP APNEA (OSA) QUESTIONNAIRE

"Yes" response equals 1 point

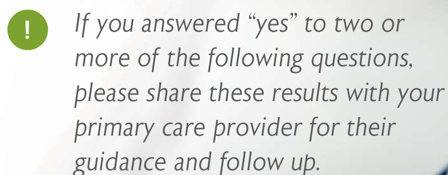
1. Do you snore loudly?
   (Louder than talking or loud enough to be heard through closed doors)
2. Has anyone observed you to stop breathing during your sleep?
3. Is your BMI more than 35?
   (Body Mass Index: Google "body mass index calculator" for a tool to help you determine your BMI)
4. Are you over 50 years old?
5. Do you often feel tired, fatigued or sleepy during the day?
6. Do you have or are you being treated for high blood pressure?
7. If you are a man, Is your neck circumference greater than 16 inches (40 cm)?
   If you are a woman, do you wear an XL blouse size?
8. Are you a male?

Total Score

High risk of OSA:
Yes 5 – 8

Intermediate risk of OSA:
Yes 3 – 4

Low risk of OSA:
Yes 0 – 2



! *If you answered "yes" to two or more of the following questions, please share these results with your primary care provider for their guidance and follow up.*

BLOOD PRESSURE GUIDELINES

To determine whether your blood pressure is normal, your doctor examines your systolic and diastolic pressures. These pressures are measured in millimeters of mercury (abbreviated as mmHg).

Normal	At risk (prehypertension)	High
systolic: less than 120 mmHg	systolic: 120-139 mmHg	systolic: 140 mmHg or higher
diastolic: less than 80 mmHg	diastolic: 80-89 mmHg	diastolic: 90 mmHg or higher

Taking steps to maintain healthy blood pressure levels *

1. Check your blood pressure
2. Eat a healthy diet
3. Maintain a healthy weight
4. Move more
5. Don't smoke
6. Limit alcohol use
7. Prevent or manage diabetes

cdc.gov

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Franciscan EXPRESSCARE

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AUTHORIZATION FOR TREATMENT

EMPLOYEE NAME: ______________________ SS# ______________________

COMPANY NAME: Skyline Property Group ______________________

COMPANY PHONE # (317) 865-8818 ______________________ FAX # ______________________

Company Representative Authorizing Treatment (print name): ______________________

Company Representative Authorizing Treatment (e-mail): ______________________

Company Representative Signature: ______________________ Phone # ______________________

The above employee is scheduled on: Date: ______________________ Time: ______________________

Check Appropriate Clinic *(See reverse side for clinic maps)*

Franciscan WorkingWell locations: Choose one of these locations for your employee's occupational health needs.

- ☐ CityWay 325 S. Alabama St., Suite 100, Indianapolis, IN 46204, Tel (317) 705-4785, Fax (317) 705-4798
- ☐ Greenwood 747 E. County Line Rd., Greenwood, IN 46143, Tel (317) 528-8009, Toll Free (877) 516-5777, Fax (317) 528-8012
- ☐ Mooresville 1215 Hadley Rd., Suite 205 Mooresville, IN 46158, Tel (317) 834-5220, Fax (317) 834-5229
- ☐ Carmel 10767 Illinois St., Suite 1300, Carmel, IN 46032, Tel (317) 528-2777, Fax (317) 528-2778
- ☐ Crawfordsville 1704 Lafayette Rd., Suite 2, Crawfordsville, IN 47933, Tel (765) 362-6374
- ☐ Lafayette 3218 Daugherty Drive, Suite 140, Lafayette, IN 47909 Tel (765) 502-4190

Franciscan ExpressCare locations: Choose one of these when the WorkingWell locations are closed and on weekends.

- ☐ Stones Crossing 1703 W. Stones Crossing, Greenwood, IN 46143, Tel (317) 528-2141
- ☐ Greenwood 1001 N. Madison Ave., Greenwood, IN 46142, Tel (317) 528-7500
- ☐ Indianapolis 5210 E. Thompson Rd., Indianapolis, IN 46237, Tel (317) 782-7500
- ☐ CityWay 325 S. Alabama Street, Suite 100, Indianapolis, IN 46204, Tel (317) 705-4785
- ☐ Carmel 10767 Illinois St., Suite 1300, Carmel, IN 46032, Tel (317) 528-2777, Fax (317) 528-2778

Check Services Needed

Diagnosis & Treatment ☐ Injury Treatment

Physical Examination ☐ DOT ☐ Non-DOT ☐ Pre-placement ☐ Other: ______________________

Check Type of Drug Testing Needed

☐ Non-DOT Urine Drug Screen (Chain of Custody)

☐ DOT Urine Drug Screen (Chain of Custody)

☐ Instant Urine Drug Screen (5-panel E-Cup) ☐ Instant Urine Drug Screen (10-panel) ☐ Other: ______________________

☐ Collection Only Urine Drug Screen ☐ Non-DOT ☐ DOT ☐ Laboratory: ______________________

☐ Breath Alcohol ☐ Non-DOT ☐ DOT

☐ Hair Analysis ☐ Other: ______________________

Check Reason For Drug Test

☐ Pre-Placement ☐ Random

☐ Reasonable Suspicion / Cause *(Select one of the following: Post Accident, Injury or Other)*

☐ Post-Accident ☐ Post-Injury ☐ Other: ______________________

Check Any Additional Services Needed *(Note: Call for availability.)*

☐ Respirator Questionnaire ☐ Spirometry Testing ☐ Wellness Screenings ☐ Lift Evaluations

☐ Respirator Fit Testing ☐ Audiometric Exams ☐ Vaccinations

☐ Other: ______________________

INTERNAL USE ONLY Verbal Authorization from:

WW Signature: ______________________

Date: Time:

Franciscan WORKINGWell

RECORD RELEASE REQUEST

First Name | Middle Initial | Last Name

Address | Birth Date

City | State | Zip

Patient Signature | Date

Dear Dr. | Date

I am applying for a Department of Transportation (DOT) medical certificate. In order for me to pass my physical and to ***continue my employment or to qualify for employment***, I need a letter from you regarding my medical condition(s) (listed below) and a statement of compliance with treatment including the degree of control and documentation of any pertinent laboratory tests for the conditions listed below.

Please, at your earliest convenience review and verify, via signing below, that I am under your care for the stated condition(s), that I am maintaining appropriate follow-up resulting in the condition being adequately controlled, and that I am ***deemed safe to drive*** according to the standards set forth by the Federal Motor Carrier Safety Administration (FMCSA). See link below with page number reference next to Medical Condition listed below.

https://www.fmcsa.dot.gov/sites/fmcsa.dot.gov/files/docs/mission/advisory-committees/mrb/83401/fmcsamedicalexaminerhandbook.pdf

Please fax this information to Franciscan WorkingWell at: (765) 362-6375 at your earliest convenience.

Thank you for your time. I do appreciate your help.

Medical Condition(s)

- ☐ Diabetes, P. 172
- ☐ Cardiovascular Conditions, P. 73
- ☐ Hypertension, P. 65
- ☐ Respiratory Issues, P. 117
  - ☐ Sleep Apnea, P. 117
  - ☐ Emphysema, P. 117
  - ☐ Chronic Asthma, P. 117
- ☐ Vision Issues. P. 52
- ☐ Hearing Issues, P. 59
- ☐ Cognitive Impairment, P. 186

Other:

Other:

Provider's Printed Name:

Provider's Signature: | Date

1704 Lafayette Road, Suite 1 Crawfordsville, IN 47933 (765) 362-6374 / Fax: (765) 362-6375

Instructions for Completing the Medical Examination Report Form (MCSA-5875)

I. Step-By-Step Instructions

Driver:

Privacy Act Statement - Please read, sign and date the Statement acknowledging that you understand the provisions of the Privacy Act of 1974 as written.

Section 1: Driver information

- **Personal Information**: Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, gender, driver's license number and issuing state.
  - **CLP/CDL Applicant/Holder**: Check "yes" if you are a commercial learner's permit (**CLP**) or com-mercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a com-mercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combina-tion weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to trans-port 16 or more passengers, including the driver; or (4) is used to transport either hazardous materi-als requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
  - **Driver ID Verified By**: The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
  - **Question: Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box “yes” or “no” and if you aren't sure check the “not sure” box.
- **Driver Health History**:
  - **Have you ever had surgery:** Please check “yes” if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
  - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check “yes” if you are taking any diet supplements, herbal remedies, or prescrip-tion or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
  - **#1-32:** Please complete this section by checking the “yes” box to indicate that you have, or have ever had, the health condition listed or the “No” box if you have not. Check the “not sure” box if you are unsure.
  - **Other Health Conditions not described above**: If you have, or have had, any other health condi-tions not listed in the section above, check “Yes” and in the box provided and list those condition(s).
  - **Any yes answers to questions #1-32 above:** If you have answered “yes” to any of the questions in the Driver Health History section above, please explain your answers further in the box below the ques-tion. For example, if you answered “yes” to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked “yes” to ques-tion #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

Public Burden Statement
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 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

____

(or sticker)

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: ______

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)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: ____________ First Name: ____________ 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)