U.S. Department of Transportation Federal Motor Carrier Safety Administration	ıtion
Individual's Name:	

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INSULIN-TREATED DIABETES MELLITUS ASSESSMENT FORM

	INSULIN-IREATED DIABETES WELLITUS ASSESSMEN	I FORM
Na	Name:	DOB:
Dr	Driver's License Number (if applicable):	State:
Ferhanda abi	This individual is being evaluated either to determine whether he/she meets the physic Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor has recently experienced a severe hypoglycemic episode. A treating clinician should compability based on his/her knowledge of the individual's medical history. Completion of this clinician is making a medical certification decision to qualify the individual to drive a determination as to whether the individual is physically qualified to drive a commercial certified medical examiner on FMCSA's National Registry of Certified Medical Examiner	vehicle or because the individual lete this form to the best of his/her form does not imply that a treating commercial motor vehicle. Any motor vehicle will be made by a
	FMCSA defines a treating clinician as a healthcare professional who manages, and pressindividual's diabetes mellitus as authorized by the healthcare professional's applicab	
Ins	Instructions to the Individual:	
	When you are being evaluated prior to a medical certification examination, the certified mand begin the examination no later than 45 calendar days after a treating clinician si	
	When you are being evaluated after a severe hypoglycemic episode, you must retain thi medical examiner at your next medical certification examination.	s form and give it to the certified
Ins	Insulin-Treated Diabetes Mellitus Diagnosis	
1.	1. Date insulin use began:	
Ble	Blood Glucose Self-Monitoring Records	
2.	2. Has the individual maintained at least the preceding 3 months of ongoing blood gluco being treated with insulin that are measured with an electronic glucometer that stores time of readings, and from which data can be electronically downloaded? YesNo	
3.	3. Has the individual provided at least the preceding 3 months of electronic self-monito with insulin from his/her glucometer to the treating clinician for review? YesNo	ring records while being treated

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U.S. Department of Transportation Federal Motor Carrier Safety Administration OMB Control Number: 2126-0006 Expiration Date: 11/30/2021

	eral Motor Carrier Safety Administration
Ind	ividual's Name:
	If no, provide details:
pei mo do	te: The individual is not physically qualified to operate a commercial motor vehicle for up to the maximum 12-month riod until he/she provides a treating clinician with at least the preceding 3 months of electronic blood glucose self-intoring records while being treated with insulin. At the certified medical examiner's discretion, the individual who es not possess at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated the 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?
	Comments (if necessary):
Se	vere 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. YesNo
	If yes, provide date(s) of occurrence, whether the cause has been addressed, and associated details (attach additional pages as needed):
He	moglobin 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? YesNo
	If yes, attach the most recent result.
Dia	abetes 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)? YesNo
	If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

Yes No

Individual's Name: ___ 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)? 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)? If yes, provide the date of diagnosis, location, type of involvement, current treatment, and whether the condition is 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?

If yes, provide date of diagnosis:

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U.S. Department of Transportation

Street Address

Federal Motor Carrier Safety Administration 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) 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

City, State, Zip Code