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: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 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 to determine whether he/she meets the physical qualification standards of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle in interstate commerce. The individual’s 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 the treating clinician is making a medical certification decision to qualify the individual to drive a commercial motor vehicle. The determination whether the above 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.

The certified medical examiner must receive this form and begin the medical certification examination no later than 45 calendar days after the treating clinician signs this form.

*FMCSA defines 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.*

**Insulin-Treated Diabetes Mellitus Diagnosis**

1. Date insulin use began:
2. Is this a new insulin-treated diabetes mellitus individual? *FMCSA defines a new insulin-treated diabetes mellitus individual as an individual diagnosed as having diabetes mellitus whose treatment with insulin was recently initiated and who is not able to provide at least 30 days of electronic blood glucose self-monitoring records to the treating clinician.*

\_\_\_\_\_Yes \_\_\_\_\_No

1. Is the individual an established insulin-treated diabetes mellitus individual? *FMCSA defines an established insulin-treated diabetes mellitus individual as an individual diagnosed as having diabetes mellitus that is treated with insulin, who has provided electronic blood glucose self-monitoring records according to the specific treatment plan prescribed by the treating clinician, and who has provided the treating clinician with electronic blood glucose self-monitoring records for at least the preceding 3 months.*

\_\_\_\_\_Yes \_\_\_\_\_No

If yes, has the individual been on a stable insulin regimen for the preceding 3 months?

\_\_\_\_\_Yes \_\_\_\_\_No

Note: Established insulin-treated diabetes mellitus individuals cannot be medically certified until 3 months of blood glucose self-monitoring records have been provided to the treating clinician. New insulin-treated diabetes mellitus individuals with less than 30 days of blood glucose self-monitoring records may only be considered for medical certification for a maximum of 30 days.

**Blood Glucose Self-Monitoring Records**

1. Has the individual maintained documentation of ongoing blood glucose self-monitoring records 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

1. Has the individual provided electronic monitoring records from his/her glucometer to the treating clinician for review?

\_\_\_\_\_Yes \_\_\_\_\_No

1. How many times per day is the individual testing his/her blood glucose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is the individual compliant with blood glucose monitoring based on his/her specific treatment plan?

\_\_\_\_\_Yes \_\_\_\_\_No

Comments (*if necessary*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Insulin Management and Diabetes Control**

1. Has the individual experienced any severe hypoglycemic episodes within the preceding 3 months? *FMCSA defines a severe hypoglycemic episode as requiring the assistance of others, or resulting in loss of consciousness, seizures, or coma.*

 \_\_\_\_\_Yes \_\_\_\_\_No

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Hemoglobin A1C (HbA1C) Measurements**

1. 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.

**Diabetes Complications**

1. Does the individual have signs of diabetic complications or target organ damage? *This information will be used by the medical examiner in determining whether the listed conditions would impair the individual’s ability to safely operate a commercial motor vehicle.*
2. 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. 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: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. 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:

1. 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:\_\_\_\_\_\_\_\_\_\_\_\_

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1. Other? (*specify condition*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Yes \_\_\_\_No

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

**Progressive Eye Diseases**

1. Date of last comprehensive eye examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?

\_\_\_Yes \_\_\_\_No

If yes, provide date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Additional Comments (*if necessary, attach additional pages as needed*)

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I certify that I am the individual’s treating clinician (as defined above) and that this individual maintains a stable insulin regimen and proper control of his/her insulin-treated diabetes mellitus.

Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Medical Credential Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional License Number and State

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Phone Number Email

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Street Address City, State, Zip Code