**MCSA-5870**

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



# 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

3. 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

4. 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

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

6. How many times per day is the individual testing his/her blood glucose? _____

7. Is the individual compliant with blood glucose monitoring based on his/her specific treatment plan?
_____Yes _____No

Comments (*if necessary*): _____
_____

## Insulin Management and Diabetes Control

8. 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*): _____
_____
_____

## Hemoglobin A1C (HbA1C) Measurements

9. 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

10. 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.*

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. 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)?
____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, location, type of involvement, 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? (*specify condition*)_____
____Yes ____No

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

**Progressive Eye Diseases**

11. Date of last comprehensive eye examination: _____

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

If yes, provide date of diagnosis: _____

13. 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: _____
_____
_____

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

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

_____ _____
Phone Number Email

_____ _____
Street Address City, State, Zip Code