

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

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**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*

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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: _____
Medication: _____	Dosage: _____	Date started: _____
Medication: _____	Dosage: _____	Date started: _____

**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):  
 \_\_\_\_\_  
 \_\_\_\_\_
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):  
 \_\_\_\_\_  
 \_\_\_\_\_
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):  
 \_\_\_\_\_  
 \_\_\_\_\_

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**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.

**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:

\_\_\_\_\_

\_\_\_\_\_

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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*