OMB APPROVAL NO 1405-XXXX
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: XX MINUTES

U.S. Department of State
Bureau of Medical Services

DRIVER MEDICAL EXAMINATION: DIABETES MELLITUS* ASSESSMENT FORM

Instructions: This form is required for all individuals with diabetes who are treated with insulin and must be provided at the time of the initial or periodic medical evaluation.

*This form is required for insulin-treated diabetes and may be required for individuals with diabetes who are not insulin treated, based on clinical judgment of the reviewing Driver Medical Evaluation clinician. Failure to provide this form prior to or during the evaluation may result in disqualification or delays in the evaluation process.

This form should be completed by the medical provider/clinician who manages the driver's diabetes and who prescribes insulin and/or other medication for the treatment of diabetes mellitus.

Section I: Driver Information

Name *(Last, First, MI)*	Date of Birth (*mm-dd-yyyy*)

Section II: Diabetes History

Approximate date of diabetes mellitus diagnosis (*mm-yyyy*)): _____

MEDICATION

Insulin Use? ☐ Yes ☐ No or N/A	If "Yes", Date Insulin Use Began (mm-dd-yyyy)	If "Yes", Current Insulin Regimen

Other medications used to manage diabetes.	Name of Medication	Dose	Frequency

BLOOD GLUCOSE

Is the individual compliant with monitoring based on his/her specific treatment plan? ☐ Yes ☐ No	If "Yes", how many times per day is the individual testing his/her blood glucose?	If, "Yes", I, the clinician, reviewed the stated individual's blood glucose monitoring results from _____ Date (mm-dd-yyyy)

HYPOGLYCEMIC EPISODES

A severe hypoglycemic episode is one that results in symptoms such as loss of consciousness, seizure, or coma or resulted in emergency room evaluation or hospitalization.

Has the individual experienced any severe hypoglycemic episodes within the preceding 3 months? ☐ Yes ☐ No	If "Yes", Date of Occurrence (*mm-dd-yyyy*)	If "Yes", has the cause been addressed? ☐ Yes ☐ No	If, "Yes", provide details.

HbA1C

Has the individual had HbA1C measured intermittently over the last 12 months including a recent measurement within the last 3 months? ☐ Yes ☐ No	Provide a copy of the most recent result and enter the result here (*including mm-dd-yyyy obtained*).

Name of Examinee	**DOB**

DIABETIC COMPLICATIONS

Renal disease/renal insufficiency (*e.g., diabetic nephropathy, proteinuria*)? ☐ Yes ☐ No	Diabetic cardiovascular disease (*e.g., coronary artery disease, hypertension, stroke*)? ☐ Yes ☐ No
Neurological disease/autonomic neuropathy (*e.g., cardiovascular, gastrointestinal*)? ☐ Yes ☐ No	Peripheral neuropathy (e.g., sensory loss, loss of vibratory sense)? ☐ Yes ☐ No
Lower limb (e.g., foot ulcers, gangrene, infection)? ☐ Yes ☐ No	

If any of the above answers are yes:	Date of Dianosis (*mm-dd-yyyy*)	Current Treatment?	Stable Condition? ☐ Yes ☐ No

PROGRESSIVE EYE DISEASE(S)

Date of last comprehensive eye exam (*mm-dd-yyyy*)):? _____

Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy? ☐ Yes ☐ No	If "Yes", Date of Diagnosis (*mm-dd-yyyy*)

Has the individual been diagnosed with any other progressive eye disease(s) (*e.g., macular degeneration, cataracts, glaucoma*)? ☐ Yes ☐ No	If "Yes", Date of Diagnosis *(mm-dd-yyyy*)	If, "Yes", Current Treatment	If "Yes", Stable Condition? ☐ Yes ☐ No

RESTRICTIONS

Are there any local (host nation) restrictions related to insulin treated diabetes (or non-insulin treated diabetes) and professional driving? ☐ Yes ☐ No	If, "Yes", provide details.

COMMENTS

Treating clinician should comment here on treatment plan if HBA1c is above 10, if recent hypoglycemic episodes, and/or if diabetic complications.

Name of Examinee	DOB

Section III: Provider/Clinician Recommendation

_____ (initial): I attest that I am a treating clinician and have treated the individual's diabetes mellitus for _____ (# of years).	IF LESS THAN 1 YEAR Please comment below on your knowledge of this individual's diabetes treatment plan.

Based on my assessment above, performed on _____ (mm-dd-yyyy):

- ☐ The individual can safely drive, without restrictions.
- ☐ The individual can safely drive with the following restrictions/limitations: _____
- ☐ The individual should not drive at this time.

Name of Provider/Clinician	Signature of Provider/Clinician	Medical Credential/Specialty

Clinic Address/Post	Phone Number	Email

***Note**: even if the documentation indicates the individual can drive, this document will be reviewed as part of the overall driver medical evaluation and in accordance with the US Department of State Bureau of Medical Services Driver Medical Evaluation Policy.

Paperwork Reduction Act Statement

Releases or disclosures of confidential medical information are governed by the Privacy Act of 1974, as amended, 5 U.S.C. § 552a et seq., and the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 701 et seq.

Privacy Act Statement

AUTHORITIES: The information is sought pursuant to 5 CFR 930.108, 339.301 and the Foreign Service Act of 1980, as amended (Title 22 U.S.C. 4084, 3901, and 3984).

PURPOSE: The information requested on this form will be used to determine medical eligibility for issuance of a driver medical certificate.

ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. The information may also be made available to local Health Units. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records

DISCLOSURE: Providing this information is voluntary; however, failure to provide this information may result in denial of a driver medical certification.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

To the individual and/or health care provider completing the medical history review /exam: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.