

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):

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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):

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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*