

6. Date of initial diagnosis of diabetes mellitus: _____

Treatment for diabetes mellitus prior to insulin use:

None Diet Oral agent

7. Insulin Usage:

Date insulin use began: _____

Type of insulin(s) and current dosage now used: _____

Length of time on current dose: _____

Is the applicant compliant with his/her insulin regimen? YES NO

If patient uses insulin pump, current average daily dose: _____

8. FMCSA defines a **severe hypoglycemic reaction** as one that results in:

Seizure, or

Loss of consciousness, or

Requiring assistance of another person, or

Period of impaired cognitive function that occurred without warning.

In the last 5 years, while being treated for diabetes, has the patient had recurrent (2 or more) severe hypoglycemic episodes? YES NO

In the last 12 months, while being treated for diabetes, has the patient had a severe hypoglycemic episode? YES NO **(If no proceed to #9 below)**

If yes, provide information on each hypoglycemic episode:

Date(s):

Include additional information about each episode including symptoms of hypoglycemic reaction, treatment, and suspected cause:

Was the patient hospitalized? YES NO

If yes, provide brief summary of hospitalization:

Has the patient's treatment regimen changed since the last hypoglycemic episode?

YES NO

Briefly explain changes:

9. Additional Information or History (If none, write *none*):

10. List all medications including those taken related to the treatment of diabetes (if none, write none):

Name of Medication	Dose	Reason for Taking the Medication

11. In your medical opinion, does any one of the listed medications have the potential to compromise the driver’s ability to operate a CMV safely?
 YES NO

If yes, which medication(s): _____

12. Associated Medical Conditions (please check *yes* or *no*):

Renal Disease	Renal insufficiency	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Proteinuria	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Nephrotic Syndrome	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cardiovascular Disease	Coronary artery disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Hypertension	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Transient ischemic attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Peripheral vascular disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Neurological Disease	Autonomic neuropathy (i.e, cardiovascular GI, GU)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Peripheral Neuropathy (Circle one below)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Sensory		
	Decreased sensation		
	Loss of vibratory sense		
	Loss of position sense		

If the applicant has been or is currently being treated for any of the above medical conditions, provide relevant additional information (consultation notes, special studies, follow-up reports, and hospital records).

13. Stable Insulin Regimen/Glucose Measurements:

A. Background and criteria:

The driver should have stable control and no risk of hypoglycemia and hyperglycemia while operating a CMV.

30 day requirement: An individual diagnosed with diabetes mellitus who had been previously treated with oral medication, and who now requires insulin, should have at least a 1-month period on insulin to establish stable control.

60 day requirement: An individual newly diagnosed with diabetes mellitus, who is now starting insulin, should have at least a 2-month period on insulin to establish stable control.

B. Glucose Measurements:

A CMV driver **should not have large fluctuations in blood glucose levels. The determination of a patient's stable control is left to the treating endocrinologist.**

a. I have reviewed the patient's daily glucose monitoring logs while using insulin.

YES NO

b. Does the patient have any large fluctuations that may impact safe driving?

YES NO

14. Since beginning insulin use, has the patient received education in the management of diabetes that includes diet, monitoring, recognition and treatment of hypoglycemia and hyperglycemia? YES NO

If yes, please provide last education date (MM/YYYY): _____

Note: The applicant must participate in a diabetes education program at least annually to apply for and remain in the diabetes exemption program.

15. I hereby certify that in my medical opinion, this applicant understands how to individually manage and monitor his/her diabetes mellitus. YES NO

16. In my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage their diabetes. YES NO

17. I hereby certify that in my medical opinion, the applicant is able to safely operate a commercial motor vehicle (large truck or motor coach) in interstate commerce while using insulin. YES NO

18. Please attach your office letterhead with your printed/typed name, signature, date, medical license number, and state of issue to this checklist.