# *DOT Medical Clearance: AORTIC REGURGITATION*

# DOT Physical Exam Medical Clearance

**Patient** _____

**Date** _____

**DOB** _____

The above driver has presented for a DOT medical certificate to drive a commercial motor vehicle. Per Federal Motor Carrier Safety Administration medical guidelines, we ask for your professional opinion to determine if the driver is medically cleared to operate a commercial motor vehicle and that s/he meets the following FMCSA medical guidelines for drivers with a history of **AORTIC REGURGITATION**:

**FMCSA GUIDELINES FOR AORTIC REGURGITATION**

- The driver must be asymptomatic and have normal LV function.
- If AR is severe the LVEF must be > 50%, LVEDD $\leq$ 60 mm, and LVESD $\leq$ 50 mm
- There is a 3 month waiting period post aortic valve repair.

The demands of a commercial driver include loading/unloading heavy cargo, tarping trailers, coupling/uncoupling trailers, inspecting brake lines and putting on tire chains and require perceptual skills to monitor a complex driving situation and judgment skills to make quick decisions in addition to the ability to control an oversize steering wheel, shift gears using a manual transmission, maneuver a vehicle in crowded areas, enter and exit the cab frequently, and the ability to climb ladders on the tractor/trailer.

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*If the driver **meets** the above requirements and your recommendation is that the driver can operate a CMV safely, please sign and date below.*

_____ _____

***Provider's Signature*** ***Date***

*If the driver **does not meet** the above requirements and your recommendation is that the driver **cannot** operate a CMV safely, please sign and date below.*

_____ _____

***Provider's Signature*** ***Date***

*If the driver **does not meet** the above requirements **and it is your opinion that the driver should be allowed** to drive a commercial vehicle, DOT medical examiners may use discretion if there is sufficient medical reasoning for why the guidelines should not be followed. Should this be the case, please identify in the area below which guideline is not met, and the medical reason the driver is safe to drive.*

_____

_____

_____

_____ _____

***Provider's Signature*** ***Date***

**PRINT PROVIDER'S NAME** _____

Address (City, State, Zip): _____

**Return this letter to the patient's medical examiner by fax/email:**

_____

**Thank you for your assistance.**