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Return to Duty / Work DOT Clearance Form

Please use this form to provide additional information related to the medical condition defined below. This information is necessary for our assessment of a driver's ability to safely operate a commercial motor vehicle.

Patient Information: (Please Print)

Last Name: First: Middle:

Date of Birth: / / Date of Exam: / /

Supplemental Medical Information:

The above patient has presented for their DOT medical examination noting a history of

Please provide the following information so the medical examiner may complete the DOT medical examination. By signing below, you are only attesting to the patient's defined medical condition.

Diagnosis:

Procedure(s) Performed: Date: / /

Date: / /

Date: / /

Medication (Including Dosage):

Patient may return to work without restrictions? Check one: ☐ YES ☐ NO

Date patient may return to work without restrictions: / /

The patient has the following restrictions:

Follow-up Date: / /

Treating Medical Provider Recommendation

Treating Medical Provider:

Given your knowledge of the patient's medical condition, do you feel they can safely operate a commercial motor vehicle? Check one: ☐ YES ☐ NO

Provider: Signature: Date: / /

Thank you for providing the requested information. Please email or fax the completed form to our office.

FOR DOT STOP MED STAFF USE ONLY:

Medical Examiner: Signature: Date: / /