VANDERBILT HEALTH AT MNPS HEALTH CARE CENTERS

Fessey Court	2494 Fessey Court, Nashville, TN 37204	Phone (615) 259-8755	Fax (615) 244-0520
Stratton A	306 W Old Hickory Boulevard, Madison, TN 37115	Phone (615) 259-8755	Fax (615) 865-6360
Stratton B	306 W Old Hickory Boulevard, Madison, TN 37115	Phone (615) 259-8755	Fax (615) 868-3112
Two Rivers	2995 McGavock Pike, Nashville, TN 37214	Phone (615) 259-8755	Fax (615) 232-3865
Mt. View	3812 Murfreesboro Road, Antioch, TN 37013	Phone (615) 259-8755	Fax (615) 641-2280
West	655 Colice Jeanne Road, Nashville, TN 37221	Phone (615) 259-8755	Fax (615) 646-9190

COMMERCIAL DRIVER CERTIFICATION DETERMINATION – OBSTRUCTIVE SLEEP APNEA (OSA)

Exam Date _____
DOT Driver _____
DOB _____

The above individual has presented to the clinic for a Commercial Driver Fitness Determination in accordance with U.S. Code of Federal regulation 49 CFR 391.41. During the examination, the following was noted:

_____
_____
_____

Driver Consent for Release of Medical Information

I, _____, hereby authorize the release to MNPS Health Care Centers for the following information.

___ All medical records and reports
___ Other _____

Patient Signature _____ Date _____
Patient Print Name _____

Statement of Personal Physician

According to the U.S. Code of Federal Regulation Title 49 part CFR 391.41 (b)(5) states "A person is physically qualified to drive a commercial motor vehicle if that person has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with his/her ability to control and drive a motor vehicle safely". This includes OSA. CMV drivers with OSA must provide documentation of effective treatment annually. If using CPAP, time on pressure documentation is needed. Annual evaluation by a sleep specialist and assessment of compliance must be done for OSA drivers.

I have read and understand the regulation and guidelines cited above and on the following page. I verify the individual has no current diagnosis of OSA likely to interfere with his/her ability to operate a commercial motor vehicle safely. The condition and treatment will not cause imminent risk of daytime drowsiness or other symptoms that would affect the individual's ability to operate a commercial vehicle safely.

Physician Signature _____ Date _____
Physician Print Name _____
Specialty _____
Phone _____
Address _____
_____

PLEASE FAX TO OUR _____ LOCATION AT FAX NUMBER _____