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
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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 – CARDIOVASCULAR ASSESSMENT

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
___ Medical information on cardiovascular diagnosis
___ Latest lipid panel
___ Latest blood pressure readings
___ Electrocardiograms, Echocardiograms, and Exercise Treadmill Test (Nuclear Stress Test if applicable)
___ 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)(4) states "A person is physically qualified to drive a commercial motor vehicle if that person: *Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure*".

I have read the above and understand the regulation and guidelines pertaining to the cardiovascular disease. I verify that the above individual has no disqualifying cardiovascular disease and is not at risk for sudden incapacitation that would affect the ability to safely operate a commercial vehicle.

PLEASE INCLUDE DOCUMENTATION TO SUPPORT THIS STATEMENT.

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

PLEASE FAX TO OUR _____ LOCATION AT FAX NUMBER _____