VANDERBILT HEALTH AT MNPS HEALTH CARE CENTERS

Fessey Court	2494 Fessey Court, Nashville, TN 37204	Phone (615) 259-8755	Fax (615) 244-0520
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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 – EPILEPSY

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
___ EEG
___ Diagnostic imaging
___ Laboratory reports
___ Other _____

Date of last seizure _____
Date when stopped anti-seizure medication(s) _____

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)(8) states "A person is physically qualified to drive a commercial motor vehicle if that person: *Has no current established medical history or clinical diagnosis of epilepsy or any condition which is likely to cause loss of consciousness or and loss of ability to control a motor vehicle*".

The following drivers CANNOT be qualified: (1) a driver who has a medical history of epilepsy; (2) a driver who has a current clinical diagnosis of epilepsy; or (3) a driver who is taking anti-seizure medications. The guidelines allow a driver with a history of a single seizure to be certified based on the cause, length of time since the seizure, and length of time off anti-seizure medications.

I have read the above and understand the regulation and guidelines cited. I verify the above named individual is in compliance with the above regulation.

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

PLEASE FAX TO OUR _____ LOCATION AT FAX NUMBER _____