



DOT Physical: Provider Letter

RE: _____

DOB: _____

Your patient is scheduled for a medical examination for certification as commercial driver under Federal Motor Carrier Safety Administration (FMCSA) regulations. Due reported use of a Scheduled Drug we are requesting that the following information be provided from the treating health care provider. Please note the following FMCSA Guidelines prior to completing this form.

Scheduled II Medications and ACOEM Guidelines on Opioid Use and Safety-Sensitive Work (JOEM 2014; 56)

*“A person is physically qualified to drive a commercial motor vehicle if that person –
Does not use a controlled substance identified in 21 CFR 1308.11 Schedule I, an amphetamine, a narcotic,
or any other habit-forming drug.*

Exception: A driver may use such a substance or drug, if the substance or drug is prescribed by a licensed medical practitioner who:

Is familiar with the driver’s medical history and assigned duties; and

Has advised the driver that the prescribed substance or drug will not adversely affect the driver’s ability to safely operate a commercial motor vehicle.”

Current best practices and standard of care per ACOEM caution against the use of chronic opiates for safety sensitive work:

“Acute or chronic opioid use is not recommended for patients who perform safety-sensitive job, including operating motor vehicles or other modes of transportation that require tasks involving high levels of cognitive function and judgment. Special caution should be paid to those taking additional medications such as benzodiazepines.”

We appreciate your assistance in providing the necessary information below.

Occupational Health Examiner _____

Date _____

Please complete below and fax to Workplace Health & Wellness at 215-453-4719

How long have you been treating this patient? _____

What are the patient’s current diagnoses? _____

Is your patient’s condition considered stable? Yes ___ No ___

If no, please explain: _____

Please list current medications and dose: _____

Do you have any concerns that the prescribed substance or drug may adversely affect the driver’s ability to safely operate a CMV? Yes ___ No ___

Do you have any recommendations on the timing of medication administration in relation to driving and necessary wait times based on the half-life of the medication? Yes ___ No ___

If yes, please describe: _____

In your medical opinion, is this person able to safely operate a commercial motor vehicle considering their current diagnoses and their prescribed medications? Yes ___ No ___

If no, please explain: _____

Signature: _____ Date: _____

Physician Name: _____ Phone: _____