PLEASE COMPLETE BOTH SIDES OF THIS FORM Rev 8/14/17: 12/11/2018

ISLAND HEALTH CARE PATIENT REGISTRATION FORM

Name: _____
First Middle Last

SSN __ __ __ - __ __ - __ __ __ __ Date of Birth __/ __/ __ Age ___ □ Female □ Male □ Transgender: M to F □ F to M □

Marital Status: □ Single □ Married □ Significant Other □ Divorced □ Separated □ Widowed

Sexual Orientation: □ Lesbian or Gay □ Straight □ Bisexual □ Something else □ Don't know □ Don't wish to disclose

Employment: □ Full Time □ Part Time □ Not Employed □ Self Employed □ Retired □ Military Duty

Student: □ Full Time □ Part Time □ Not a Student

_____ _____
Mailing Address (PO Box if you have one) Street Address (if different from mailing address)

_____ _____ _____ _____ _____ _____
City/Town State Zip City/Town State Zip

Phone: _____-_____-_____ □ cell □ home □ work Email: _____

EMERGENCY CONTACT _____ Phone: _____-_____-_____
Relationship to you: _____

Primary Care Provider: _____ City/State: _____

Primary Insurer: _____ **Provide card to front desk staff**
Subscriber name: _____
Secondary Insurer:_____ **Provide card to front desk staff**
Subscriber Name: _____

Financial Agreement: I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits according to the terms of my insurer's contract with Island Health Care.

Assignment of Benefits: I request that payment of authorized medical benefits be made on my behalf directly to Island Health Care for services rendered. I authorize any holder of medical information about me to release to the state and/or federal administration(s) and its agents or other insurer, any information needed to determine these benefits payable for related services. This Assignment will remain in effect until revoked by me in writing. A photocopy of this Agreement is to be considered as valid as the original.

Signature _____ Date _____/_____/_____

The following information is required by our funding sources. We will maintain this information in a strictly confidential manner. We appreciate your help.

1. Do you live in public housing? Yes__ No__ **2.** Are you a military veteran? Yes__ No__ **3.** My (family) annual income is: $_____ Total number of family members (single = 1): ___ Do not wish to report ___ **4.** Primary Language Spoken:_____ **5.** Are you homeless? (based on where you will sleep tonight) Yes____ No ___ **6.** Are you a migrant or seasonal worker? Yes____ No ___	**7.** Race: White__ Black/African American____ Alaska Native/American Indian_____ Asian _____ Native Hawaiian_____ Other Pacific Islander_____ Other (please describe): _____ Do not wish to report ___ **8.** Ethnicity: Hispanic/Latino ___Non-Hispanic/Latino___ Do not wish to report____

AUTHORIZATION FOR TREATMENT & HEALTH SERVICES

NAME_____ DOB _____

Island Health Care Community Health Center (IHC) strives to be a comprehensive health center, responding to community health needs, supporting long-term health and well-being, and empowering individuals to manage their own health and health care. We are committed to providing high quality, accessible and affordable services to all of the patients we serve. IHC providers and staff will work with you to guide and make recommendations regarding your care and treatment.

IHC provides primary care and some behavioral health services. Additional evaluation, such as laboratory, x-ray, other diagnostic studies, specialty referral and treatment, and/or more extensive studies and professional care will be the responsibility of the patient. IHC staff will help to provide assistance in arranging such services.

I understand that in order to provide services, it may be necessary for IHC to communicate with and/or refer to outside resources. I authorize IHC to share my medical information with any health care facility or medical provider as deemed necessary.

Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at www.mass.gov/dph/miis or contact the Massachusetts Immunization Program MIIS Help Desk directly at 617-983-4335

I hereby authorize medical treatment by Island Health Care. I understand that medical treatment and procedures are provided by independent practicing physicians or nurse practitioners.

I agree to:

a) give Island Health Care accurate information regarding other providers and facilities who/which are providing health care services to me.

b) participate in the decisions regarding my care and follow recommendations of Island Health Care providers that we mutually agree upon.

c) inform Island Health Care regarding any changes in health and/or reactions to treatment and medications, including pain.

d) provide Island Health Care with insurance or financial information as requested, and to notify Island Health Care of any changes in my insurance and financial circumstances. I understand that my not doing so may create a situation in which I am responsible for payment of services and charges associated with my care.

e) treat Island Health Care personnel with respect.

I understand that it may take 48 to 72 hours to receive certain test results and renewal of prescriptions.

I am aware that some prescription renewals may require that I be seen to reevaluate my treatment plan.

I understand that I am responsible for all of my personal effects during a health center visit.

I retain the right to seek treatment elsewhere at my own expense.

The services of Island Health Care and its professional staff are available during posted health center hours. After-hours answering, nurse triage and provider on-call services may be accessed by calling 508-939-9358. Please refer to the After-Hours Policy posted at the entrance of the health center.

I agree to notify Island Health Care 24 hours in advance if I am unable to keep my appointment.

I understand that if I have any questions or concerns about this form or any health center services or policies, I may arrange to meet with a staff member during health center hours.

I understand that if my insurance provider requires a referral and I do not provide one at the time of my visit to Island Health Care, I may be responsible for the bill.

Patient Signature_____ Date ____/ ____/ ____

Island Health Care

PATIENT MEDICAL HISTORY UPDATE FORM for DOT EXAM

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

MEDICATION ALLERGIES

□ None □ Yes, please list _____

FAMILY HEALTH HISTORY

Relation to you	Age	Health Status	Significant Health Problem
Father		□ In good health □ In stable health □ In poor health □ Deceased	
Mother		□ In good health □ In stable health □ In poor health □ Deceased	

Any other pertinent family medical history:_____
_____

IMMUNIZATION HISTORY

Flu Shot? Date: _____ Where: _____ (Note flu season is 10/1 – 3/31)

Tetanus/TD/TDaP? Date: _____ Where: _____

CANCER SCREENINGS

Ages 50 – 85 only:
Colonoscopy date: _____ Where: _____ □Never

Women only:
Pap smear date: _____ Where: _____ □Total Hysterectomy

TOBOCCO USE

□ Never smoked □ Light smoker □ Heavy smoker □Former smoker

How many years quit?____ # of yrs:_____

□ Cigarettes___ pks/day □ Chew__#day □ Pipe__#day □ Cigars__ #day
(Include electronic cigarettes)

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

_____

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ◯ Yes ◯ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ◯ Yes ◯ No ◯ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: ○ Yes ○ No Height: ___ *feet* ___ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading *(optional)*		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other testing if indicated

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/_____	20/_____	Right Eye: _____ degrees
Left Eye:	20/_____	20/_____	Left Eye: _____ degrees
Both Eyes:	20/_____	20/_____	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

*Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	_____	_____

OR

Audiometric Test Results

Right Ear:			Left Ear:		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
_____	_____	_____	_____	_____	_____

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	**Body System**	Normal	Abnormal
1. General	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Genito-urinary system including hernias	○	○
3. Eyes	○	○	10. Back/spine	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Neurological system including reflexes	○	○
6. Cardiovascular	○	○	13. Gait	○	○
7. Lungs/chest	○	○	14. Vascular system	○	○

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

○ Does not meet standards *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*

○ Determination pending *(specify reason)*: _____

☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____

☐ Medical Examination Report amended *(specify reason)*: _____

(if amended) Medical Examiner's Signature: _____ Date: _____

○ Incomplete examination *(specify reason)*: _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):

○ Does not meet standards in 49 CFR 391.41 with any applicable State variances *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41 with any applicable State variances

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements *(State)*

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____

Instructions for Completing the Medical Examination Report Form (MCSA-5875)

I. Step-By-Step Instructions

Driver:

Section 1: Driver Information

- **Personal Information:** Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, driver's license number and issuing state.
  - **CLP/CDL Applicant/Holder:** Check "yes" if you are a commercial learner's permit (**CLP**) or commercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
  - **Driver ID Verified By:** The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
  - **Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box "yes" or "no" and if you aren't sure check the "not sure" box.
- **Driver Health History:**
  - **Have you ever had surgery:** Please check "yes" if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
  - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check "yes" if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
  - **#1-32:** Please complete this section by checking the "yes" box to indicate that you have, or have ever had, the health condition listed or the "No" box if you have not. Check the "not sure" box if you are unsure.
  - **Other Health Conditions not described above:** If you have, or have had, any other health conditions not listed in the section above, check "Yes" and in the box provided and list those condition(s).
  - **Any yes answers to questions #1-32 above:** If you have answered "yes" to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered "yes" to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked "yes" to question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

Medical Examiner:

Section 2: Examination Report

- **Driver Health History Review:** Review answers provided by the driver in the driver health history section and discuss any "yes" and "not sure" responses. In addition, be sure to compare the medication list to the health history responses ensuring that the medication list matches the medical conditions noted. Explore with the driver any answers that seem unclear. Record any information that the driver omitted. As the Medical Examiner conducting the driver's physical examination you are required to complete the entire medical examination even if you detect a medical condition that you consider disqualifying, such as deafness. Medical Examiners are expected to determine the driver's physical qualification for operating a commercial vehicle safely. Thus, if you find a disqualifying condition for which a driver may receive a Federal Motor Carrier Safety Administration medical exemption, please record that on the driver's Medical Examiner's Certificate, Form MCSA-5876, as well as on the Medical Examination Report Form, MCSA-5875.
- **Testing:**
  - **Pulse rate and rhythm, height, and weight:** record these as indicated on the form.
  - **Blood Pressure:** record the blood pressure (systolic and diastolic) of the driver being examined. A second reading is optional and should be recorded if found to be necessary.
  - **Urinalysis:** record the numerical readings for the specific gravity, protein, blood and sugar.
  - **Vision:** The current vision standard is provided on the form. When other than the Snellen chart is used, give test results in Snellen-comparable values. When recording distance vision, use 20 feet as normal. Record the vision acuity results and indicate if the driver can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors; has monocular vision; has been referred to an ophthalmologist or optometrist; and if documentation has been received from an ophthalmologist or optometrist.
  - **Hearing:** The current hearing standard is provided on the form. Hearing can be tested using either a whisper test or audiometric test. Record the test results in the corresponding section for the test used.
- **Physical Examination:** Check the body systems for abnormalities and indicate normal or abnormal for each body system listed. Discuss any abnormal answers in detail in the space provided and indicate whether it would affect the driver's ability to safely operate a commercial motor vehicle.

In this next section, you will be completing either the Federal or State determination, not both.

- **Medical Examiner Determination (Federal):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49). Complete the medical examiner determination section completely. When determining a driver's physical qualification, please note that English language proficiency (49 CFR part 391.11: General qualifications of drivers) is not factored into that determination.
  - **Does not meet standards:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41.
  - **Meets standards in 49 CFR 391.41; qualifies for 2-year certification:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting "other" specify the time frame.
  - **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, driving within an exempt intracity zone, etc.).
- **Determination pending:** Select this option when more information is needed to make a qualification decision and specify a date, on or before the 45 day expiration date, for the driver to return to the medical exam office for follow-up. This will allow for a delay of the qualification decision for as many as 45 days. If the disposition of the pending examination is not updated via the National Registry on or before the 45 day expiration date, FMCSA will notify the examining medical examiner and the driver in writing that the examination is no longer valid and that the driver is required to be re-examined.
  - **MER amended:** A Medical Examination Report Form (MER), MCSA-5875, may only be amended while in determination pending status for situations where new information (e.g., test results, etc.) has been received or there has been a change in the driver's medical status since the initial examination, but prior to a final qualification determination. Select this option when a Medical Examination Report Form, MCSA-5875, is being amended; provide the reason for the amendment, sign and date. In addition, initial and date any changes made on the Medical Examination Report Form, MCSA-5875. A Medical Examination Report Form, MCSA-5875, cannot be amended after an examination has been in determination pending status for more than 45 days or after a final qualification determination has been made. The driver is required to obtain a new physical examination and a new Medical Examination Report Form, MCSA-5875, should be completed.
- **Incomplete examination:** Select this when the physical examination is not completed for any reason (e.g., driver decides they do not want to continue with the examination and leaves) other than situations outlined under determination pending.
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

- **Medical Examiner Determination (State):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations). Complete the medical examiner determination section completely.
  - **Does not meet standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41 with any applicable State variances.
  - **Meets standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting "other" specify the time frame.
  - **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, etc.).
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

II. If updating an existing exam, you must resubmit the new exam results, via the Medical Examination Results Form, MCSA-5850, to the National Registry, and the most recent dated exam will take precedence.

III. To obtain additional information regarding this form go to the Medical Program's page on the Federal Motor Carrier Safety Administration's website at http://www.fmcsa.dot.gov/regulations/medical.