ADOT
Motor Vehicle Division
40-1506 R10/14 azdot.gov

Mail Drop 818Z
Medical Review Program
PO Box 2100
Phoenix AZ 85001-2100

ENDOCRINOLOGIST EVALUATION ARIZONA INTRASTATE DIABETES WAIVER PROGRAM CHECKLIST

Clear

Driver Identifying Information

Name:(first, mi, last)	
Address: (city, state, zip code)	
DOB (mm/dd/yyyy)	AZ DL Number

This applicant is applying for an Arizona Intrastate diabetes waiver to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in intrastate commerce. Part of the application process is an evaluation by a board-certified or board-eligible Endocrinologist to determine if the individual has any medical problem related to diabetes that might impair safe driving.

The applicant's examination by an Endocrinologist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

1. ❑ I am board certified in endocrinology
   ❑ I am eligible in endocrinology

If neither, do not continue your assessment. Applicants must be evaluated by an endocrinologist who is board-certified or board-eligible.

2. Office Telephone number: _____Office Fax number: _____

3. Date of most recent examination:
(mm/dd/yyyy)_____

4. I am familiar with the patient's medical history for the past 5 years through a records review, treating the patient or consultation with the treating physician.

❑ YES ❑ NO

A review of the applicant's 5 year medical history is required. If the history is not available, please state the reason.

_____

_____

_____

5. Date of initial diagnosis of diabetes mellitus:_____

Treatment for diabetes mellitus prior to insulin use:

❑ None ❑ Diet ❑ Oral agent

6. Insulin Usage:
Date insulin use began:_____

Type of insulin(s) and current dosage now used:_____

Length of time on current dose:_____

Is the applicant compliant with his/her insulin regimen? ❑ YES ❑ NO

If patient uses insulin pump, current average daily dose:_____

7. FMCSA defines a **severe hypoglycemic reaction** as on that results in:
Seizure, or
Loss of consciousness, or
Requiring assistance of another person, or
Period of impaired cognitive function that occurred without warning.

In the last 5 years, while being treat for diabetes, has the patient had recurrent (2 or more) severe hypoglycemic episodes?. ❑ YES ❑ NO

In the last 12 months, while being treated for diabetes has the patient had a severe hypoglycemic episode? ❑ YES ❑ NO (if no proceed to #9 below)

If yes, provide information on each hypoglycemic episode:
Date(s):_____
Include additional information about each episode including symptoms of hypoglycemic reaction, treatment, and suspected cause:

_____

_____

_____

Was the patient hospitalized? . ❑ YES ❑ NO
If yes, provide brief summary of hospitalization:

_____

_____

_____

Has the patient's treatment regimen changed since the last hypoglycemic episode

❑ YES ❑ NO

Briefly explain changes:

_____

_____

_____

8. Additional Information or History (if none, write none)

_____

_____

_____

9. List all medications including those taken related to the treatment of diabetes (if none, write none)

Name of Medication	Dose	Reason for Taking The Medication

10. In your medical opinion, does any one of the listed medications have the potential to compromise the driver's ability to operate a CMV safely?

❑ YES ❑ NO

If yes, which medication(s):_____

_____

11. Associated Medical Conditions (please check yes or no):

Renal Disease	Renal insufficiency	❑ YES ❑ NO
	Proteinuria	❑ YES ❑ NO
	Nephrotic Syndrome	❑ YES ❑ NO
Cardiovascular Disease	Coronary artery disease	❑ YES ❑ NO
	Hypertension	❑ YES ❑ NO
	Transient ischemic attack	❑ YES ❑ NO
	Stroke	❑ YES ❑ NO
	Peripheral vascular disease	❑ YES ❑ NO
Neurological Disease	Autonomic neuropathy(i.e., cardiovascular GI, GU)	❑ YES ❑ NO
	Peripheral Neuropathy	❑ YES ❑ NO
	If yes is check one below	
	❑ Sensory	
	❑ Decreased sensation	
	❑ Loss of vibratory sense	
	❑ Loss of position sense	

If the applicant has been or is currently being treated for any of the above medical conditions, provide relevant additional information (consultation notes, special studies, follow-up reports, and hospital records).

12. Stable Insulin Regimen/Glucose Measurements:

A. Background and criteria:
The driver should have stable control and no risk of hypoglycemia and hyperglycemia while operation a CMV

30 day requirement: An individual diagnosed with diabetes mellitus who had been previously treated with oral medication, and who now requires insulin, should have at least a 1-month period on insulin to establish stable control.

60 day requirement: An individual newly diagnosed with diabetes mellitus, who is now starting insulin, should have at least a 2-month period on insulin to establish stable control.

B. Glucose Measurements:
A CMV driver should not have large fluctuations in blood glucose levels. The determination of a patient's stable control is left to the treating endocrinologist.

a. I have reviewed the patient's daily glucose monitoring logs while using insulin.

❑ YES ❑ NO

b Does the patient have any large fluctuations that may impact safe driving?

❑ YES ❑ NO

13. Since beginning insulin use, has the patient received education in the management of diabetes that includes diet, monitoring, recognition and treatment of hypoglycemia and hyperglycemia? ❑ YES ❑ NO

If yes, please provide last education date (mm, dd, yyyy)

Note: The applicant must participate in a diabetes education program at least annually to apply for and remain in the diabetes waiver program.

14. I hereby certify that in my medical opinion, this applicant understands how to individually manage and monitor his/her diabetes mellitus

❑ YES ❑ NO

15. In my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage their diabetes.

❑ YES ❑ NO

16. I hereby certify that in my medical opinion, the applicant is able to safely operate a commercial motor vehicle (large truck or motor coach) in intrastate commerce while using insulin.

❑ YES ❑ NO

Printed name	Signature
License Number	Today's date
Date of Expiration	State of Issue