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

96-1508 R10/14 azdot.gov

ENDOCRINOLOGIST QUARTERLY EVALUATION ARIZONA INTRASTATE DIABETES WAIVER PROGRAM CHECKLIST

Driver Identifying Information

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

This applicant was granted an Arizona Intrastate Diabetes waiver from the Arizona Department of Transportation (ADOT) diabetes standard to operate a commercial motor vehicle (CMV) in intrastate commerce. QUARTERLY medical monitoring and reporting is a condition of the waiver from the diabetes standard of Arizona Administrative code (AAC) R17-5-208 and 49 CFR 391.41 (b) (3).

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 have reviewed the patient's daily glucose logs (from his/her glucose monitoring device).

❑ YES ❑ NO

5. I have compared monitoring dates to his/her driving log to ensure that the individual is checking glucose levels prior to operating a CMV as required.

❑ YES ❑ NO

If **NO**, please comment:____

6. I certify that this individual's glucose levels have been maintained in the range of 100 to 400 mg/dl while driving a CMV.

❑ YES ❑ NO ❑ N/A

7. I certify that this individual continues to maintain a stable insulin regimen and that his/her glycosylated hemoglobin (AIC) result continues to reflect stable control of his/her insulin treated diabetes mellitus (ITDM).

❑ YES ❑ NO

8. 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 3 months, while being treated for diabetes has the patient had a severe hypoglycemic episode? ❑ YES ❑ NO .

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:

____

____

____

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

Please send this completed annual vision checklist to:

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If you have any questions or need additional information, please call 602-771-2460.