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Cardiac DOT Clearance Form

Please use this form to provide additional information related to the medical condition defined below. This information is necessary for our assessment of a driver's ability to safely operate a commercial motor vehicle.

Patient Information: (Please Print)

Last Name: ____________________ First: ____________________ Middle: ____________________

Date of Birth: ___/___/___ Date of Exam: ___/___/___

Supplemental Medical Information:

The above patient has presented for their DOT medical exam and either noted a history of ____________________ ____________________ or it was identified during our testing, requiring further evaluation and management.

Please provide the following information so the medical examiner may complete the DOT medical examination. By signing below, you are only attesting to the patient's defined medical condition.

Diagnosis: ____________________

Procedure(s) Performed: ____________________ Date: ___/___/___

____________________ Date: ___/___/___

____________________ Date: ___/___/___

Medication (Including Dosage): ____________________

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Testing: Please note, DOT regulations require an EST be performed every two years following stent placement or MI. An annual EST is required 5 years post CABG.

Testing Performed: ____________________ Date: ___/___/___

Results: ____________________

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Treating Medical Provider Recommendation

Treating Medical Provider:

Given your knowledge of the patient's medical condition, do you feel they can safely operate a commercial motor vehicle? Check one: ☐ YES ☐ NO

Provider: ____________________ Signature: ____________________ Date: ___/___/___

Thank you for providing the requested information. Please email or fax the completed form to our office.

FOR DOT STOP MED STAFF USE ONLY:

Medical Examiner: ____________________ Signature: ____________________ Date: ___/___/___