# DOT Physical: Musculoskeletal Disorder - Provider Letter/Status Report

RE: _____ SS #_____

Dear Dr. _____,

Your patient is scheduled for a medical examination for certification as commercial driver and/or mobile equipment operator under Federal Motor Carrier Safety Administration (FMCSA) regulations. Due to a history of musculoskeletal disorder, The Occupational Health Center at Chester County Hospital Penn Medicine has requested that the following information be provided from the treating health care provider for documentation of treatment and effective control of this medical condition.

***A person is physically qualified to drive a commercial motor vehicle if that person-***

***"Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease which interferes with his/her ability to control and operate a commercial motor vehicle safely."***

We would appreciate your assistance in providing the necessary information below in order for us to determine if this individual qualifies for medical certification. Please refer to the FMCSA certification/recertification Guidance sheet for the specific musculoskeletal disorder and complete the questions below. Thank you for your assistance.

_____ _____
Occupational Health Examiner Date

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***Please complete below and fax to The Occupational Health Center at 610 738- 2471***

How long have you been treating this patient?_____

What is the current medical diagnosis?_____

Is your patient's condition stable? _____Yes _____No

If no, please explain_____

Please list current medications and dose_____

_____

_____

Have you advised your patient that the prescribed substance or drug may adversely affect the driver's ability to safely operate a CMV? _____Yes _____No

***In your medical opinion, is this person able to safely operate a commercial motor vehicle or mobile equipment considering the complex physical and mental requirements with the current diagnosis and medication use?*** _____Yes _____No

If no, please explain_____

_____

Signature _____ Date: _____

Physician name _____ Tel. # _____



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