D.O.
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NAME: _____ DATE: _____

DATE OF BIRTH: _____

QUESTIONNAIRE FOR MEDICAL CERTIFICATION

What is/are the diagnosis for which you treat this patient?

_____

_____

What medication(s) is the patient taking (Name, dose, schedule)?

_____

_____

_____

Is the patient compliant with medical appointments and the treatment program?_____

Is the treatment efficacious?_____

Is the patient tolerating treatment without side effects such as sedation, impaired coordination, etc that would cause safety sensitive risks?_____

In your medical opinion does the patient have a medical condition and/or treatment plan that would result in a higher than acceptable likelihood for gradual or sudden incapacitation or sudden death that would endanger public safety?_____

Are any accommodations required for this patient? _____

Physician Signature:_____Date:_____

Stamp or complete below
Physician Name, Address and Phone Number: