New York State Department of Motor Vehicles

DS-874 (1/09)

# EXAMINATION TO DETERMINE MEDICAL CONDITION OF DRIVER UNDER ARTICLE 19-A

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***INSTRUCTIONS TO MEDICAL EXAMINER:***

- *For New/Initial Examinations and Recertification–complete* **ALL** *items on pages 1 through 4 of the form and sign where indicated on page 4.*
- *For Follow-up Examinations–complete* **ONLY** *those items which require follow-up information and/or evaluation from a prior examination. Sign the form where indicated on page 4.*

## DRIVER INFORMATION *(to be completed by the driver and reviewed by the medical examiner)*

| Driver's Last Name | First | M.I. | Date of Birth (Month/Day/Year) | Age | Sex ☐ Male ☐ Female |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Client/License ID Number (from Driver License) | State | Class of Driver's License | Endorsements | Restrictions | Expiration Date |
|---|---|---|---|---|---|
| | | | | | |

## CARRIER INFORMATION *(to be completed by driver or driver's carrier)*

| Carrier/DBA Name | Legal Name (if different) | Federal ID Number | 19-A Business ID Number |
|---|---|---|---|
| | | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

## Section 1A - HEALTH HISTORY *(to be completed by the driver and reviewed by the medical examiner)*

| | YES | NO | |
|---|---|---|---|
| 1. | ☐ | ☐ | Any illness or injury in the last 5 years? |
| 2. | ☐ | ☐ | Head/Brain injuries, disorders or illnesses |
| 3. | ☐ | ☐ | Seizures, epilepsy |
| 4. | ☐ | ☐ | Eye disorders or impaired vision (except corrective lenses) |
| 5. | ☐ | ☐ | Ear disorders, loss of hearing or balance |
| 6. | ☐ | ☐ | Heart disease or heart attack; other cardiovascular condition |
| 7. | ☐ | ☐ | Heart surgery (valve replacement/bypass, angioplasty, pacemaker) |
| 8. | ☐ | ☐ | High blood pressure |
| 9. | ☐ | ☐ | Muscular disease |
| 10. | ☐ | ☐ | Shortness of breath |
| 11. | ☐ | ☐ | Lung disease, emphysema, asthma, chronic bronchitis |
| 12. | ☐ | ☐ | Kidney disease, dialysis |
| 13. | ☐ | ☐ | Liver disease |
| 14. | ☐ | ☐ | Digestive problems |
| 15. | ☐ | ☐ | Diabetes or elevated blood sugar controlled by *(check all that apply)*: ☐ diet ☐ insulin ☐ other medication |
| 16. | ☐ | ☐ | Incident of hyperglycemic or hypoglycemic shock |
| 17. | ☐ | ☐ | Loss of, or altered consciousness |
| 18. | ☐ | ☐ | Fainting, dizziness |
| 19. | ☐ | ☐ | Nervous or psychiatric disorders, e.g., severe depression |
| 20. | ☐ | ☐ | Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring |
| 21. | ☐ | ☐ | Stroke or paralysis |
| 22. | ☐ | ☐ | Missing or impaired hand, arm, foot, leg, finger, toe |
| 23. | ☐ | ☐ | Spinal injury or disease |
| 24. | ☐ | ☐ | Chronic low back pain |
| 25. | ☐ | ☐ | Regular, frequent alcohol use |
| 26. | ☐ | ☐ | Narcotic or habit forming drug use |
| 27. | ☐ | ☐ | Tuberculosis |
| 28. | ☐ | ☐ | Other ______________________________ |

***For any YES answer, indicate the number listed above for the condition, onset date, diagnosis, treating medical examiner's name and address, and any current conditions. List all medications (including over-the-counter medications) used regularly or recently. Attach additional sheets as necessary.***

______________________________________________

______________________________________________

______________________________________________

***I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate this examination.***

Driver's Signature ✍ ______________________________ Date ______________

| Date of Examination |
|---|
| |

Driver's Name: Last ________________ First ________________ MI _____ Driver's License/ Client ID #________________

## Section 1B - HEALTH HISTORY *(to be completed by the medical examiner)*

### VISION

**Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.**

**INSTRUCTIONS:** When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. ***Monocular drivers are not qualified.***

**Numerical readings must be provided.**

| ACUITY | UNCORRECTED | CORRECTED | HORIZONTAL FIELD OF VISION |
|---|---|---|---|
| Right Eye | 20/ | 20/ | Right Eye ○ |
| Left Eye | 20/ | 20/ | Left Eye ○ |
| Both Eyes | 20/ | 20/ | |

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors . . . . . . ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing Corrective Lenses . . . . . . . ☐ Yes ☐ No

Monocular Vision. . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No

Complete next two lines only if vision testing is done by an ophthalmologist or optometrist.

________________ Date of Examination

________________ Name of Ophthalmologist or Optometrist (print)

________________ Telephone Number

________________ License Number/State of Issue

✍ ________________ (Signature of Examiner)

### HEARING

Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or
b) average hearing loss in better ear ≤ 40 dB

☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

**INSTRUCTIONS:** To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3. **Numerical readings must be recorded.**

| a) Record distance from individual at which forced whispered voice can first be heard. | Right ear | Left ear |
|---|---|---|
| | \Feet | \Feet |

**OR**

| b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI Z24.5-1951) | Right Ear | | | Left Ear | | |
|---|---|---|---|---|---|---|
| | 500Hz | 1000 Hz | 2000 Hz | 500Hz | 1000 Hz | 2000 Hz |
| | | | | | | |
| | Average: | | | Average: | | |

### BLOOD PRESSURE/PULSE RATE

**Numerical reading must be recorded. Medical Examiner should take at least two readings to confirm BP.**

| **Blood Pressure** | Systolic | Diastolic |
|---|---|---|
| | | |

**Pulse Rate:** ☐ Regular ☐ Irregular **Record Pulse Rate:** ________________

### LABORATORY AND OTHER TEST FINDINGS

**Numerical readings must be recorded.**

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. Other Testing (Describe and record)

________________

________________

________________

**URINE SPECIMEN**

| SP. GR | PROTEIN | BLOOD | SUGAR |
|---|---|---|---|
| | | | |

**Driver's Name:** Last ______________________ First ____________ MI _____ **Driver's License/ Client ID #**________________

## Section 2 - PHYSICAL EXAMINATION *(to be completed by the medical examiner)*

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. Attach additional sheets if necessary. If organic disease is present, note that it has been compensated for.

**Height** __________ **(in.)** **Weight** __________ **(lbs.)**

| BODY SYSTEM | CHECK FOR: | Yes* | No |
|---|---|---|---|
| 1. General appearance | Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse. | ☐ | ☐ |
| 2. Eyes | Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate. | ☐ | ☐ |
| 3. Ears | Scarring of tympanic membrane, occlusion of external canal, perforated eardrums. | ☐ | ☐ |
| 4. Mouth and Throat | Irremediable deformities likely to interfere with breathing or swallowing. | ☐ | ☐ |
| 5. Heart | Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator. | ☐ | ☐ |
| 6. Lungs and chest, not including breast examination | Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/ or xray of chest. | ☐ | ☐ |
| 7. Abdomen and Viscera | Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness. | ☐ | ☐ |
| 8. Vascular System | Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins. | ☐ | ☐ |
| 9. Genito-urinary System | Hernias. | ☐ | ☐ |
| 10. Extremities- Limb impaired. Driver may be subject to SPE certificate if otherwise qualified. | Loss or impairment of leg, foot, toe, arm, hand, finger, perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly. | ☐ | ☐ |
| 11. Spine, other musculoskeletal | Previous surgery, deformities, limitation of motion, tenderness. | ☐ | ☐ |
| 12. Neurological | Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski reflexes, ataxia. | ☐ | ☐ |

*** COMMENTS:**

**Driver's Name:** Last ______ First ______ MI ____ **Driver's License/ Client ID #**______

## Section 3 - MEDICAL EXAMINER'S CERTIFICATION *(to be completed by the medical examiner)*

☐ New/Initial Certification ☐ Recertification ☐ Follow-Up

☐ **Restrictions and/or follow-up:**

- ☐ Qualified only when wearing corrective/contact lenses.
- ☐ Qualified - Certification required every six months for diabetic condition.
- ☐ Qualified only when wearing a hearing aid.
- ☐ Qualified only by use of prosthetic devices or equipment modifications.

  Description/Type: ______
- ☐ Meets standards, but periodic monitoring required due to______

  Driver qualified only for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ Other______

**REMARKS:**

______

______

______

______

______

I certify that I have examined ______ in accordance with the Commissioner's
(Print Driver's Full Name)

Regulations and with knowledge of the driver's duties. In accordance with Commissioner's Regulation 6.10 or 6.10-a, I find:

- ☐ the person named above is physically or medically qualified.
- ☐ the person named above is physically or medically qualified with **Restrictions and/or Follow-up** as detailed above.
- ☐ the person named above **IS NOT** physically or medically qualified because ______

______

______ (Print Name of Examining Physician, P.A., Advanced Practice Nurse or Nurse Practitioner)

______ (Signature of Examiner)

______ (Address of Examining Physician, P.A., Advanced Practice Nurse or Nurse Practitioner)

______ (Date)

If the examination is conducted by a Physician's Assistant or an Advanced Practice Nurse, the Supervising Physician must certify as follows: **I certify that the individual who conducted the above examination was acting under my direction and supervision and, if applicable, in accordance with a written practice or protocol agreement.**

______ (Print Name of Supervising Physician)

______ (Signature of Supervising Physician)

**THE CARRIER MUST KEEP THE ORIGINAL EXAMINATION REPORT (NOT A PHOTOCOPY) IN THE EMPLOYEE'S 19-A FILE**

**ANY PHOTOCOPIES MUST IDENTIFY THE LOCATION OF THE ORIGINAL**