DOT PHYSICAL FORMS:

Important information for filling out DOT packet:

* Print out **SINGLE SIDED**
* Use **BLACK** INK to fill out the forms
* DO NOT date until at office for appointment
* Leave the front page with 4 squares blank--**just the 4 squares section; bottom can be completed.**
* FILL IN the very tops of pages 2, 3, 4 & 5 (Name, DOB, leave exam date empty unless coming in that day.)
* If you have numereous medications and written down, please bring it so we can copy it

  Be honest so it's not considered a felony

** Please remember to bring with you or come in 30 minutes earlier than scheduled

Kansas Commercial Driver's License Holder – Medical Self Certification

Effective: January 30, 2012

The Kansas Division of Vehicles is collecting CDL applicants' Medical Self Certification as Part of the CDL as required by Federal Motor Carrier Safety Regulations, 49 CFR Part 383, 384, 390 & 391.

Part A

_____

Name of Driver: (Print Clearly) (Last, First, Middle, Suffix)

Date of Birth: (Month)_____(Day)_____(Year)_____

Kansas Driver's License or Commercial License Number:_____

Today's Date: (Month)_____(Day)_____(Year)_____

Note: Only Class A, B, or C applicants that check the **first** self-certification box below must submit a copy of their valid medical certification card. (Kansas does not require the medical certification long form). All Commercial Class A, B, or C applicants must submit this self-certification upon original application, renewal, upgrade or transfer of a Kansas commercial driver's license.

The Driver's License Agency is not responsible for determining a driver's self-certification classification; that is the sole responsibility of the driver. You may submit your medical card in person to a full service exam station, you may also mail, email or fax in your medical card.
Mail: P.O. Box 2188 Topeka, KS 66601-2188. Email: kdor_medical.certification@ks.gov Fax: 785-296-5859

Part B

I certify my commercial transportation is: *(Check only one of the following categories that apply to you).*

☐ Category 1. Interstate, and I am both subject to and meet 49 CFR Part 391. (***Copy of DOT medical card*** *and this certification must be submitted to the State Driver's License Agency) (Complete reverse side of this form).*

☐ Category 2. Interstate, but operating exclusively in transportation or operations excepted under 49 CFR 390.3(f), 391.2, 391.68, or 398.3. (*Only this certification must be submitted to the State Driver's License Agency).*

☐ Category 3. Intrastate, and I am both subject to and meet State driver medical qualification requirements. (*Requires driver to carry medical card; however, only this certification must be submitted to the State Driver's License Agency).* ***(Requires Intrastate only "K" restriction on CDL credential)***

☐ Category 4. Intrastate, but operating exclusively in transportation or operations excepted from all or part of the State driver qualification requirements. (*Only this certification must be submitted to the State Driver's License Agency).* ***(Requires Intrastate only "K" restriction on CDL credential)***

_____

Driver's Signature (Required) *Date (mm/dd/yy)*

Daytime Phone w/Area Code:_____

Email address:_____

2100 Kansas Ave – Great Bend, KS 67530 - (620) 792-1386

Notice of Privacy Practices Signature Page

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Daniel L. Murray Jr., D.C. - Privacy Officer

Address: 2100 Kansas Ave - Great Bend KS. 67530

Telephone No.: (620) 792-1386

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

MURRAY
CHIROPRACTIC CENTER

Danny Murray, D.C.
Scie Murray, D.C.
2100 Kansas Avenue
Great Bend, KS 67530
620-792-1386 • 800-847-3363
Fax: 620-792-8634

MEDICAL AUTHORIZATION

I, _____, hereby authorize Daniel L. Murray Jr., D.C. / FMCSA Medical Examiner Registry # 1493258010 to release a copy of my Medical Examination Report for Commercial Driver Fitness Determination related to a DOT physical completed on _____, to my employer, _____.

By my authorization to release my medical record, I hereby release Daniel L. Murray Jr., D.C. / FMCSA Medical Examiner Registry # 1493258010 from any and all liability associated with my requested release of information. This release of liability only applies to the provision of a copy of my medical record, herein described, to my employer.

I understand that I am not obligated to release my Medical Examination Report for Commercial Driver Fitness Determination to my employer. I voluntarily choose to do so.

Dated: _____ _____
Signature of Employee

MURRAY
CHIROPRACTIC CENTER

Danny Murray, D.C.
Scile Murray, D.C.
2100 Kansas Avenue
Great Bend, KS 67530
620-792-1386 • 800-847-3363
Fax: 620-792-8634

DRIVER DISCLOSURE

NOTICE TO ALL DRIVERS. YOU MUST READ AND SIGN THIS AGREEMENT. IF YOU ARE IN DISAGREEMENT WITH THIS STATEMENT, WE WILL *NOT* BE ABLE TO COMPLETE YOUR FMCSA DOT EXAMINATION TODAY.

I understand I am bound to **FULL DISCLOSURE OF MY HEALTH HISTORY TO THE BEST OF MY KNOWLEDGE**, and to comply with all the Rules and Regulations of 49CFR 391.41 under "Qualifications for Drivers". If I do not fully disclose such information to:

Examiner Name: Daniel L. Murray Jr., D.C.

Examiner FMCSA Medical Examiner Registry #: 1493258010

I may be subject to penalties, fines, and/or imprisonment under the applicable laws via the jurisdiction of the Federal Motor Carrier Safety Administration.

I UNDERSTAND I MUST DISCLOSE ANY AND ALL OF MY MEDICAL HISTORY TO THE MEDICAL EXAMINER FOR CURRENT OR PAST, DIAGNOSED, TREATED OR UNTREATED CONDITIONS.

PLEASE BE AWARE THESE ARE FEDERAL FORMS. IF YOU DO NOT LIST THE *NAMES OF ALL YOUR MEDICATION*, IT IS POSSIBLE THAT YOU WILL BE CHARGED WITH A FELONY IF YOUR PHYSICAL IS AUDITED.

Driver Signature: _____

Driver Name: _____

Date: _____

I acknowledge that office staff explained the content of this form: _____ (Initial)

_____ Signature of Witness _____ Date

Murray Chiropractic Center Financial Policy

DOT PHYSICALS

DOT Physicals are a cash service and either you or your company are expected to pay at the time of service unless prior arrangements have been made with your employer. We have arrangements for billing with many companies for their employee physicals. We do NOT bill insurance for DOT Physicals.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and Murray Chiropractic Center. As a courtesy to our patients, our office will complete and file necessary forms with your primary insurance carrier to help you collect. You are responsible for letting us know when your Explanation of Benefits for each visit has come back from your primary insurance carrier if you have a secondary carrier that you need billed as well.

You understand and agree that services rendered are ultimately your financial responsibility. You are responsible for deductibles, copays, co-insurance and any amounts that insurance does not pay for any reason. If you make overpayment, we can refund you or overages can be kept on your account for up to 90 days for future visits. Items such as decompression, nutrition, Biofreeze, ice packs and kinesiotape are not covered by insurance and are expected to be paid for in full at the time of purchase.

If you have a large deductible that has not been met, you will be expected to pay for all services in full at the time they are performed. Please keep in mind that we cannot guarantee that your insurance will pay and some policies either have no coverage or very limited coverage for chiropractic.

Depending on your insurance company, we may be considered "in-network" or "out-of-network". We will do our best to keep you apprised of the status, but you are responsible for anything insurance doesn't cover whether we are in or out of network. If we are not in-network with your insurance company, we will bill your insurance company, but you are expected to pay in full for services at the time they are performed.

PATIENTS WITHOUT INSURANCE

All services are expected to be paid for in full at the time of service. If other temporary arrangements need to be made, please discuss this with our office manager. All nutrition and other physical items must be paid for in full at the time of purchase.

ON THE JOB INJURY

We do not accept Worker's Compensation cases. If you have been injured at work and wish to be seen, you will be expected to pay for services as they are rendered and it will NOT be billed to your personal health insurance.

PERSONAL INJURY OR AUTO ACCIDENT

We accept these types of cases only in current patients on a case-by-case basis. Please present your auto insurance information immediately. You are personally responsible for your bill, but we will wait for payment from the auto carrier as long as you are an active patient. This will NOT be billed to personal health insurance.

MEDICARE

We accept assignment from Medicare, but they will only cover active care adjustments of the spine. They do NOT cover required exams and re-exams, therapies, extraspinal adjustments or maintenance care. Once the Medicare deductible is met, Medicare will pay 80% of approved adjustments. The patient is responsible for payment in full on all services that go towards deductible, for their 20% co-insurance and for all non-covered services. Payment on non-covered services are due the day they are rendered. If you have a secondary policy, please let us know. If the secondary policy is an automatic cross-over policy, Medicare will file for you. If it is not, you are responsible for filing and we can provide the necessary forms.

THINGS YOU SHOULD DO TO HELP US FILE YOUR INSURANCE

1. Present your driver's license or state I.D., insurance and/or Medicare card to be copied and kept in your file.
2. Our office policy is that any non-covered service, co-pay or deductible must be paid as services are rendered. Please be prepared to do so.
3. If you change insurance policies, insurance companies or become eligible for Medicare, please notify us immediately so that we can update your file to send claims to the correct place.
4. You are asked to authorize Murray Chiropractic Center to furnish information regarding your case to your insurance company and to assign all benefits as a result of this claim. This permits us to follow up if benefits are other than anticipated and to keep up with any developments with your insurance company.

I agree to abide by the policies stated on this form.

*Signature:*_____ *Date:*_____

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #
_____
(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ○ Yes ○ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See Instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ Yes ○ No ○ Not Sure

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY (continued)

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.15, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: ○ Yes ○ No Height: ___ *feet* ___ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading *(optional)*		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Other testing if indicated

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

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

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/____	20/____	Right Eye: ____ degrees
Left Eye:	20/____	20/____	Left Eye: ____ degrees
Both Eyes:	20/____	20/____	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard		

OR

Audiometric Test Results

Right Ear:			Left Ear:		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

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 neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Genito-urinary system including hernias	○	○
3. Eyes	○	○	10. Back/spine	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Neurological system including reflexes	○	○
6. Cardiovascular	○	○	13. Gait	○	○
7. Lungs/chest	○	○	14. Vascular system	○	○

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

○ Does not meet standards *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*

○ Determination pending *(specify reason)*: _____

☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____

☐ Medical Examination Report amended *(specify reason)*: _____

(if amended) Medical Examiner's Signature: _____ Date: _____

○ Incomplete examination *(specify reason)*: _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: Daniel L. Murray Jr., DC

Medical Examiner's Address: 2100 Kansas Ave City: Great Bend State: KS Zip Code: 67530

Medical Examiner's Telephone Number: (620)-792-1386 Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: Kansas License 01-05318 Issuing State: KS

☐ MD ☐ DO ☐ Physician Assistant ☒ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: 1493258010

Medical Examiner's Certificate Expiration Date: _____

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):

○ Does not meet standards in 49 CFR 391.41 with any applicable State variances *(specify reason)*: _____

○ Meets standards in 49 CFR 391.41 with any applicable State variances

○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements *(State)*

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: Daniel L. Murray Jr., DC

Medical Examiner's Address: 2100 Kansas Ave City: Great Bend State: KS Zip Code: 67530

Medical Examiner's Telephone Number: (620)792-1386 Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: Kansas License 01-05318 Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☒ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: 1493258010

Medical Examiner's Certificate Expiration Date: _____