Minnesota Department of Transportation

Office of Freight and Commercial Vehicle Operations
Mail Stop 420
395 John Ireland Boulevard
St. Paul, MN 55155-1899

Phone: 651/215-6330
Fax: 651/366-3718

Deaf/Hard-of-Hearing Driver Waiver Application
Physician's Examination Report Checklist

Dear Licensed Physician:

The patient before you is applying for a waiver from the medical standards for commercial vehicle drivers. We are asking your cooperation in examining the patient according to the criteria listed below. Please check the appropriate statements and certify their accuracy by placing your signature and today's date at the bottom of the report.

I examined _____ on _____ 200_____.
I understand that the examination is a precondition, required by the Minnesota Department of Transportation, of a person who applies for a waiver from the qualification requirements contained in the Federal Motor Carrier Safety Regulations at 49 CFR 391.41(b)(11), and adopted by Minnesota Statutes. I fully understand what type of examination the Minnesota Department of Transportation requires and, therefore, based on my review of the patient's (applicant's) history and physical exam, I declare:

_____The patient has not suffered an onset of hearing loss or a dramatic change of hearing within the last 12 months;

_____The patient does not have episodes of dizziness, vertigo, or balance problems;

_____The patient's former and current physicians have never diagnosed the patient as possibly having recurring episodes of vertigo, dizziness, or balance problems; and

_____The patient satisfactorily performed the following balance tests (check each test conducted):

_____Romberg Test _____Finger-to-nose Test
_____Tandem Gate Test (Heel-to-toe) _____Other: _____

Could the patient's hearing loss be improved to a hearing loss of less than 40 decibels in the better ear (at 500 Hz, 1000 Hz, and 2000 Hz) with the use of a hearing aid?

_____ Yes _____ No

I certify that the above statements are true and the applicant's condition will not adversely affect the applicant's ability to operate a motor vehicle safely.

_____ _____
Physician's name and title (please print) Minnesota License Number

_____ _____
Office/Clinic name Telephone number

_____ _____
Signature Date of examination