DEPARTMENT OF TRANSPORTATION

Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700

Dear Driver:

Please read the information in this packet carefully. It is your responsibility to provide all required information.

PLEASE NOTE: We will only process **complete** applications. All required documents must be current and accurate. We will consider your application complete *only* when it contains each of the following six items. **We will only accept and process MnDOT prescribed forms/applications.**

- ☐ Minnesota Intrastate Insulin Dependent Diabetic Driver Waiver Application;
- ☐ Complete and signed copy of the ***Medical Examination Report** (must be completed by a Medical Examiner listed on the **National Registry of Certified Medical Examiners**);
- ☐ Signed copy of the ***Medical Examiner's Certificate** (health card) (completed by a National Registry Certified Medical Examiner);
- ☐ Intrastate Insulin-Dependent Diabetic Driver Physician's Examination Report (**NOTE:** date on this report must be no more than 6 months old from the date we receive your waiver application);
- ☐ Intrastate Insulin-Dependent Diabetic Driver Eye Examination Report (**NOTE:** date on this report must be no more than 6 months old from the date we receive your waiver application); **and,**
- ☐ Clear and readable copy of your *current* driver's license (front and back). If driver's license is in renewal status, include a copy of your renewal receipt.

***NOTE**: Examiner should have the Medical Exam Report and Medical Exam Certificate forms

Included in the Insulin-Dependent Diabetic waiver packet you will find:

- This Cover Letter
- Minnesota Intrastate Insulin Dependent Diabetic Driver Waiver Application & Tennessen Warning
- Notice to Medical Examiners
- Intrastate Insulin-Dependent Diabetic Driver Physician's Examination Report
- Intrastate Insulin-Dependent Diabetic Driver Eye Examination Report

Please take the time to read the application and the attachments carefully. Review all information to ensure the driver information is complete and all required information/documentation is attached before submitting the driver waiver application packet. **MnDOT will return incomplete packets.**

There are no provisions for a temporary waiver during the application and review process. The issuance of a waiver is in no way an automatic event. Please allow enough time for review and processing.

If you have any questions regarding the application or what documents you are required to submit, please call 651-366-3700. The completed and signed application packet may be mailed to the address above, faxed to 651-366-3718, or scanned and emailed to CredentialsUnit.DOT@state.mn.us.

DEPARTMENT OF TRANSPORTATION

Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700

Minnesota Intrastate Driver Waiver Application

Vision / Insulin Dependent Diabetic

Note: MnDOT does **NOT** issue waivers for drivers of a **school bus** as defined by Minnesota Statute §169.011 subd. 71.
Please contact the Department of Public Safety for a School Bus Waiver Application:
Minnesota Department of Public Safety
Driver and Vehicle Services (School Bus/CDL Unit)
445 Minnesota Street
St. Paul, MN 55101
651-297-5029

ALLOW 30 DAYS FOR PROCESSING

(1) **TYPE OF WAIVER YOU ARE APPLYING FOR** (Mark only one)			
VISION: ☐		**INSULIN DEPENDENT DIABETIC:** ☐	
(2) **REASON FOR FILING** (Mark only one)			
NEW APPLICATION: ☐	**RENEWAL:** ☐	**UPDATE/CHANGE:** ☐	
(3) **DRIVER APPLICANT INFORMATION**			
First Name:	Last Name:	MI:	
Street:	City:	State:	Zip:
Phone Number:	Mobile Phone Number:	Email:	
Driver's License Number:	Date of Birth:		
(4) **LIST ANY OTHER MNDOT WAIVERS YOU HAVE BEEN GRANTED** (If applicable)			
Waiver Type:	Issue date:	Expiration date:	
Waiver Type:	Issue date:	Expiration date:	
(5) **CURRENT EMPLOYER** (If currently employed, please list employer information here.)			
Company Name:			
Address:	City:	State:	Zip:
Contact Person:	Business Phone Number:	Fax Number:	
Do you currently drive for this company? Yes ☐	No ☐		

Office of Freight & Commercial Vehicle Operations
395 John Ireland Blvd.
Room 153, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700

(6) **TYPE OF VEHICLE(S) YOU INTEND TO OPERATE UNDER THIS WAIVER** (Select all that apply.)			
Straight Truck: ☐	Tractor Trailer Combination: ☐	Automobile: ☐	Bus: ☐
Years:	Years:	Years:	Years:
Describe any modifications to the vehicle to accommodate your medical condition:			
Type(s) of driving you will do under the waiver:			

PLEASE READ CAREFULLY PRIOR TO SUBMITTING THE APPLICATION
Please review all information to ensure all required supporting documentation is included with your application packet; and, review the accuracy of the information. An incomplete or inaccurate application packet will delay application processing and waiver issuance.

(7) **SIGNATURE -** I certify the information provided in this application is true and accurate to the best of my knowledge. I also acknowledge that a Minnesota Intrastate Waiver is only valid between points in Minnesota while transporting freight or passengers intrastate.	
Driver's Signature:	Date:

Options to submit the required information:

Mail: Minnesota Department of Transportation
Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, MS 420, Rm 153
St. Paul MN 55155-1800
Fax: 651-366-3718
Email: CredentialsUnit.DOT@state.mn.us

DEPARTMENT OF TRANSPORTATION

Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700

Tennessen Warning

Minn. Stat. §13.04, subd. 2

In submitting your application for a driver medical waiver, you are being asked to supply information that could include private or confidential information about yourself. Before you give MnDOT permission to collect and/or release private or confidential data about you, MnDOT encourages you to review the information listed on this data privacy notice (also called a Tennessen Warning).

MnDOT is asking you to provide medical data which is classified as private data under the Minnesota Government Data Practices Act, See *Minnesota Statutes, section 13.384, subdivision 1*. MnDOT is asking you for this private information for the sole purpose of determining your eligibility for a driver medical waiver, which is issued pursuant to Minnesota Statutes, section 221.0314.

Please note that you are not legally required to provide the requested information. However, MnDOT will not be able to process your medical waiver application if you do not provide the requested information.
MnDOT does not share the protected information with any other persons or entities. With some exceptions, unless you consent to further release of the private information, release of this information will be limited to the following:

- U.S. Department of Transportation, Federal Motor Carrier Safety Administration;
- Law enforcement personnel requiring access for investigative purposes;
- Staff at the Minnesota Attorney General's Office in the event of legal action; and
- Persons who possess a court order to receive the information.

I understand that MnDOT is requesting private or confidential data about me. I give permission for MnDOT to use data about me in the way described on this form.

Signature: _____ Date: _____

Name (please print): _____

DEPARTMENT OF TRANSPORTATION

Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700

CERTIFIED MEDICAL EXAMINER EVALUATION GUIDELINES
MINNESOTA INTRASTATE INSULIN-DEPENDENT DIABETIC WAIVER PROGRAM

Driver/Applicant: Please provide to your Medical Examiner

NOTICE TO MEDICAL EXAMINERS

Your patient (a motor vehicle driver) is applying for a Minnesota Intrastate Insulin-Dependent Diabetic Driver Waiver to allow insulin use while operating a motor vehicle in intrastate commerce (between points in Minnesota). This waiver is issued under Minnesota Statutes, section 221.0314, subdivision 3a.

Medical examiners performing commercial driver medical exams must be listed on the **National Registry** of Certified Medical Examiners. Medical Examiners are expected to fully understand the medical standards of the Federal Motor Carrier Safety Regulations (FMCSRs) and related guidance. More specifically, for this waiver type, examiners must determine whether the driver meets all medical standards and guidelines, other than diabetes, in accordance with 49 CFR 391.41 (b) (1-13).

NOTE: If the applicant passes the certification except for using insulin, *please complete the following on the Medical Examination Report as well as the Medical Examiner's Certificate*:

Medical Examination Report, *Certification Status Section* –

- ☐ Meets standards but periodic monitoring required due to **insulin use.**

Driver qualified only for: (*check the box corresponding to the appropriate timeframe*)

- ☐ Accompanied by a **diabetic** or **insulin** waiver/exemption (*Figure 1, pg 2*)

Medical Examiner's Certificate –

- ☐ Accompanied by a **diabetic** or **insulin** waiver/exemption
- ☐ Medical certification expiration date *must reflect the timeframe checked on the examination report*. (*Figure 2, pg 2*)

Beyond the Insulin-Dependent Diabetic Driver Waiver—
MnDOT also accepts applications for the following additional types of waivers.

- Deaf/hard-of-hearing
- Physical: the loss or impairment of leg, foot, toe, arm, hand or fingers
- Vision

The applicant is required to submit copies of the Medical Examination Report and Medical Examiner's Certificate along with the required documents for the waiver type. We appreciate your assistance in responding to the specific requirements.

If you have questions, please call 651-366-3700.

DEPARTMENT OF TRANSPORTATION

Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700

(Figure 1)

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)*: List reason for monitoring

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

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

☐ 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.

(Figure 2)

Medical Examiner's Certificate

I certify that I have examined **Last Name:**_____ **First Name:**_____ in accordance with *(please check only one)*:

- ○ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)* **OR**
- ○ 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), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)*:

☐ Wearing corrective lenses ■ Accompanied by a Diabetic/Insulin waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*
☐ Grandfathered from State requirements *(State)*

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date
Expiration date must reflect the same date on the Medical Examination Report

Medical Examiner's Signature _____

Medical Examiner's Telephone Number _____

Date Certificate Signed _____

Medical Examiner's Name *(please print or type)* _____

○ MD ○ Physician Assistant ○ Advanced Practice Nurse
○ DO ○ Chiropractor ○ Other Practitioner *(specify)* _____

Medical Examiner's State License, Certificate, or Registration Number _____

Issuing State _____

National Registry Number _____

DEPARTMENT OF TRANSPORTATION

Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700
Fax: 651-366-3718

Intrastate Insulin-Dependent Diabetic Driver Waiver

Physician's Examination Report

Patient/Applicant Name:

Date of Exam: **DOB:**

This patient above is applying to the Minnesota Department of Transportation for a waiver from the medical standards to be able to take insulin while operating a motor vehicle in intrastate commerce. Part of the application process is an evaluation by the patient's treating physician to determine if the individual has any medical complications related to diabetes that may impair safe driving. **Note:** Based on the Federal Motor Carrier Safety Administration (FMCSA) guidelines, we will no longer accept exams that are older than 6 months from the date we receive the waiver application.

1. I am familiar with the patient's medical history through previous treatment or medical record review?
   ☐ Yes ☐ No

2. Does the patient have severe hypoglycemia? (*Low blood sugar event resulting in stupor, seizure, or unconsciousness, during which someone else's help may be required.)* ☐ Yes ☐ No

   If yes, provide additional information on how the patient manages his/her severe hypoglycemia.

3. Does the patient have hypoglycemia unawareness? *(A condition when people with diabetes have low blood sugar and do not recognize it as such.)* ☐ Yes ☐ No

   If yes, provide additional information on how the patient manages his/her hypoglycemia unawareness.

4. Within the last 3 years, did the patient have a hypoglycemic reaction that resulted in a change in mental or physical status that would have been detrimental to safe driving? ☐ Yes ☐ No

5. The patient is willing to follow your prescribed course of treatment? ☐ Yes ☐ No

In my medical opinion, I certify: 1. The applicant is willing to follow any prescribed course of treatment; and 2. The applicant's condition will not adversely affect the applicant's ability to operate a commercial motor vehicle safely.

Physicians Name and Title (Please print)

Minnesota License Number

Office/Clinic Name and Telephone Number

Signature

4/3/2019

DEPARTMENT OF TRANSPORTATION

Office of Freight & Commercial Vehicle Operations
395 John Ireland Boulevard, Mail Stop 420
St. Paul, MN 55155
Phone: 651-366-3700

Minnesota Intrastate Driver Waiver

Eye Examination Report

Patient/Applicant Name: _____

Date of Exam: _____ **DOB:** _____

The patient above is applying to the Minnesota Department of Transportation for a waiver from the medical standards for intrastate commercial motor vehicle drivers. Part of the application process is an eye examination by an optometrist or ophthalmologist to determine whether the individual has a vision deficiency that may impair safe driving.

NOTE: **(1)** If the patient (waiver applicant) has retinopathy, an ophthalmologist examination is required. **(2)** Please examine the patient according to the criteria listed below, and answer each question accordingly. **(3)** Based on the Federal Motor Carrier Safety Administration (FMCSA) guidelines, we will no longer accept eye exams that are older than 6 months for insulin-diabetic waivers and 12 months for vision waivers from the date we receive the waiver application. **(4)** Please sign and date the report.

1. I am familiar with the patient's medical history through previous treatment or medical record review?
   ☐ Yes ☐ No

2. Please identify the patient's visual deficiency: _____

3. Distant visual acuity (Snellen)

Peripheral Vision Horizontal Fields in Degree			Without Corrective Lenses	With Present Corrective Lenses	With New Corrected Lenses
Right Eye	○	Right Eye	20/	20/	20/
Left Eye	○	Left Eye	20/	20/	20/
Both Eyes	○	Both Eyes	20/	20/	20/

4. Does the patient have monocular vision? ☐ Yes ☐ No
   Note: Monocular vision occurs when the vision requirements are met in only one eye, with or without the aid of corrective lenses, regardless of cause or degree of vision loss in the other eye.

5. Does the patient have unstable proliferative diabetic retinopathy? ☐ Yes ☐ No ☐ N/A

In my medical opinion, I certify: 1. The applicant's vision is stable; 2. The applicant is willing to follow any prescribed course of treatment; 3. The applicant has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle; and 4. The applicant's condition will not adversely affect the applicant's ability to operate a commercial motor vehicle safely.

_____ _____

Ophtalmologist or Optometrist Name and Title (Please print) Minnesota License Number

_____ _____

Office/Clinic Name and Telephone Number Signature

4/3/2019