

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 five items. **We will only accept and process MnDOT prescribed forms/applications.**

- Minnesota Intrastate Driver Deaf/Hard of Hearing 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 Deaf/Hard of Hearing Physicians Examination Report;
- 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 Minnesota Intrastate Driver Deaf/Hard of Hearing Waiver Application packet you will find:

- This Cover Letter
- Minnesota Intrastate Driver Deaf/Hard of Hearing Waiver Application & Tennessee Warning
- MnDOT Notice to Medical Examiners
- Intrastate Deaf/Hard of Hearing Physicians Examination Report

Please take the time to read the application and the attachments carefully. Review all information to ensure that the driver information is complete and that all the required information/documentation is attached before submitting the driver waiver 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 are required to submit, please call 651-366-3700. The completed and signed application may be mailed to the address above, faxed to 651-366-3718, or scanned and emailed to CredentialsUnit.DOT@state.mn.us.

Minnesota Intrastate Driver Waiver Application

Deaf/Hard of Hearing

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) REASON FOR FILING (Mark only one)			
NEW APPLICATION: <input type="checkbox"/>	RENEWAL: <input type="checkbox"/>	Update/Changes: <input type="checkbox"/>	
(2) DRIVER APPLICANT INFORMATION			
First Name:		Last Name:	
Street:		City:	State: Zip:
Phone Number:	Mobile Phone Number:	Email:	
Driver's License Number:	Date of Birth:		
(3) LIST ANY OTHER MNDOT WAIVERS YOU HAVE BEEN GRANTED (If applicable)			
Waiver Type:	Issue date:	Expiration date:	
Waiver Type:	Issue date:	Expiration date:	
(4) 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 <input type="checkbox"/> No <input type="checkbox"/>			

(5) TYPE OF VEHICLE(S) YOU INTEND TO OPERATE UNDER THIS WAIVER (Select all that apply.)

Straight Truck: <input type="checkbox"/>	Tractor Trailer Combination: <input type="checkbox"/>	Automobile: <input type="checkbox"/>	Bus: <input type="checkbox"/>
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:

(6) OTHER DRIVER INFORMATION

a) What is your primary mode of communicating?
 Written English
 Lip Reading
 Sign (ASL)
 Other:

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

Tennessee 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 Tennessee 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):

**CERTIFIED MEDICAL EXAMINER EVALUATION GUIDELINES
MINNESOTA INTRASTATE DEAF/HARD-OF-HEARING 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 deaf/hard-of-hearing Waiver to allow the driver to operate 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 hearing loss, in accordance with 49 CFR 391.41 (b) (1-13).

NOTE: If the applicant passes the certification except for deaf/hard-of-hearing, 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 **monitoring reason**.
Driver qualified only for: (*check the box corresponding to the appropriate timeframe*)
- Accompanied by a **deaf/hard-of-hearing** waiver/exemption (*Figure 1, pg 2*)

Medical Examiner's Certificate –

- Accompanied by a **deaf/hard-of-hearing** waiver/exemption
- Medical certification expiration date *must reflect the timeframe checked on the examination report. (Figure 2, pg. 2)*

Beyond the Deaf/Hard-of-Hearing Driver Waiver—

MnDOT also accepts applications for the following additional types of waivers.

- Physical/Limb
- Insulin-Dependent Diabetic
- 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.

(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

Or

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): **Deaf/Hard of Hearing** _____

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 **Deaf/Hard of Hearing** 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)	<input type="radio"/> MD <input type="radio"/> Physician Assistant <input type="radio"/> Advanced Practice Nurse	
_____	<input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> Other Practitioner (specify) _____	
Medical Examiner's State License, Certificate, or Registration Number	Issuing State	National Registry Number
_____	_____	_____

**Minnesota Intrastate Driver Waiver Deaf/Hard-of-Hearing
Physician's 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 evaluation by the patient's treating physician to determine if the individual has any medical complications related to his/her hearing loss that might impair safe driving.

- 1. I am familiar with the patient's medical history through previous treatment or medical record review?
 Yes No
- 2. Has the patient suffered an onset of hearing loss or a dramatic change of hearing within the last 12 months?
 Yes No
- 3. Does the patient have episodes of dizziness, vertigo, or other balance problems?
 Yes No

If yes, list here:

- 4. Has the patient's former and/or current physician ever diagnosed the patient as having uncontrolled vertigo?
 Yes No
- 5. The patient satisfactorily performed the following balance tests (check each test conducted):
 Romberg Test Finger to nose Test Tandem Gate Test (Heel to toes)
 Other:
- 6. 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

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