MCSA-5870	OMB No.: 2126-0006
U.S. Department of Transportation	Expiration Date: 03/31/2025
Federal Motor Carrier Safety Administration	
Individual's Name:	
of information subject to the requirements of the Paperwork Reduction Act unl Control Number for this information collection is 2126-0006. Public reporting including the time for reviewing instructions, gathering the data needed, and	respond to, nor shall a person be subject to a penalty for failure to comply with a collection ess that collection of information displays a current valid OMB Control Number. The OME of this collection of information is estimated to be approximately 8 minutes per response a completing and reviewing the collection of information. Send comments regarding this gaugestions for reducing this burden to: Information Collection Clearance Officer, Federa Washington, D.C. 20590.
INSULIN-TREATED DIABET	ES MELLITUS ASSESSMENT FORM
Name:	DOB:
Driver's License Number (if applicable):	State:
Federal Motor Carrier Safety Administration (FMCSA) has recently experienced a severe hypoglycemic episode her ability based on his/her knowledge of the individual treating clinician is making a medical certification decis	whether he/she meets the physical qualification standards of the to operate a commercial motor vehicle or because the individual e. A treating clinician should complete this form to the best of his is medical history. Completion of this form does not imply that a ion to qualify the individual to drive a commercial motor vehicle ally qualified to drive a commercial motor vehicle will be made by stry of Certified Medical Examiners.
FMCSA defines a treating clinician as a healthcare profession dividual's diabetes mellitus as authorized by the health	essional who manages, and prescribes insulin for, treatment of the ecare professional's applicable State licensing authority.
Instructions to the Individual:	
When you are being evaluated prior to a medical certificathis form and begin the examination no later than 45 cales	ation examination, the certified medical examiner must receive endar days after a treating clinician signs this form.
When you are being evaluated after a severe hypoglycen medical examiner at your next medical certification exam	nic episode, you must retain this form and give it to the certified nination.
Insulin-Treated Diabetes Mellitus Diagnosis	
Date insulin use began:	
Blood Glucose Self-Monitoring Records	
	3 months of ongoing blood glucose self-monitoring records while electronic glucometer that stores all readings, records the date and inically downloaded?
☐ Yes ☐ No	
2 II 4h - in di-id1	4 61 4 1 16 14 1 1 1 1 1 1 4 4 1

3. Has the individual provided at least the preceding 3 months of electronic self-monitoring records while being treated with insulin from his/her glucometer to the treating clinician for review?

Yes No

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MCSA-5870 OMB No.: 2126-0006 Expiration Date: 03/31/2025 **U.S. Department of Transportation Federal Motor Carrier Safety Administration** Individual's Name: _ If no, provide details: **Note:** The individual is not physically qualified to operate a commercial motor vehicle for up to the maximum 12-month period until he/she provides a treating clinician with at least the preceding 3 months of electronic blood glucose selfmonitoring records while being treated with insulin. At the certified medical examiner's discretion, the individual who does not possess at least the preceding 3 months of electronic blood glucose self-monitoring records while being treated with insulin may qualify to operate a commercial motor vehicle for up to but not more than 3 months. 4. How many times per day is the individual testing his/her blood glucose? 5. Is the individual compliant with blood glucose self-monitoring based on his/her specific treatment plan? Yes No Comments, if necessary: **Severe Hypoglycemic Episodes** 6. Has the individual experienced any severe hypoglycemic episodes within the preceding 3 months? FMCSA defines a severe hypoglycemic episode as one that requires the assistance of others, or results in loss of consciousness, seizure, or coma. Yes No If yes, provide date(s) of occurrence, whether the cause has been addressed, and associated details (attach additional pages as needed): Hemoglobin A1C (HbA1C) Measurements 7. Has the individual had HbA1C measured intermittently over the last 12 months, with the most recent measure within the preceding 3 months? No Yes If yes, attach the most recent result. **Diabetes Complications** 8. Does the individual have signs of diabetic complications or target organ damage? This information will be used by the certified medical examiner in determining whether the listed conditions would impair the individual's ability to safely operate a commercial motor vehicle. Renal disease/renal insufficiency (e.g., diabetic nephropathy, proteinuria, nephrotic syndrome)? Yes No

If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:

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Individual's Name:
b. Diabetic cardiovascular disease (e.g., coronary artery disease, hypertension, transient ischemic attack, stroke peripheral vascular disease)?
☐ Yes ☐ No
If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
c. Neurological disease/autonomic neuropathy (e.g., cardiovascular, gastrointestinal, genitourinary)?
☐ Yes ☐ No
If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
d. Peripheral neuropathy (e.g., sensory loss, decreased sensation, loss of vibratory sense, loss of position sense)? Yes No
If yes, provide the date of diagnosis, location, type of involvement, current treatment, and whether the condition is stable:
e. Lower limb (e.g., foot ulcers, amputated toes/foot, infection, gangrene)? Yes No If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
f. Other? (specify condition):
∐Yes ∐No
If yes, provide the date of diagnosis, current treatment, and whether the condition is stable:
Progressive Eye Diseases
9. Date of last comprehensive eye examination:
10. Has the individual been diagnosed with either severe non-proliferative diabetic retinopathy or proliferative diabetic retinopathy?
Yes No
If yes, provide date of diagnosis:

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Individual's Name:	
11. Has the individual been diagnosed with any o	other progressive eye disease(s) (e.g., macular edema, cataracts, glaucoma)?
If yes, specify the disease(s), provide the date	es of diagnoses, current treatment, and whether the condition is stable:
12. Additional Comments (attach additional pag	es as needed)
	ned above), that this individual maintains a stable insulin regimen and es mellitus, and that the information provided is true and correct to the
D. 4.	
Date	
Printed Name and Medical Credential	Signature
Professional License Number and State	
Phone Number	Email

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