

Medical Release Opinion

Name of Primary Care Physician _____

Phone _____ Fax _____

Physician Address _____

Patient's First and Last Name _____

Patient's Date of Birth _____ Patient's Date of Last Office Visit _____

1. Medical Condition: _____

2. Date of Onset, with Diagnosis: _____

3. Course of Treatment. Medications (rx, etc, supplements): _____

4. Has treatment been shown to be adequate, effective and safe? _____

5. Is the drivers condition stable enough for him to work as a CMV Driver?

Yes _____ No _____ If no, then when _____

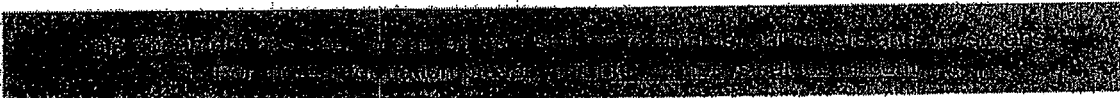
6. Is the driver released to operate a commercial motor vehicle? Yes _____ No _____

I have read and understand the job description of a commercial motor vehicle driver.

Signed by Primary Care Physician _____ Date _____

Please fax back to Certified Medical Examiner _____

fax number



Handwritten signature or initials.