

Drivers' Name _____ Date of Birth _____

Full Address _____

PHYSICIAN EVALUATION CHECKLIST

Colorado Intrastate Diabetes Waiver Program

Instructions for the Physician

Please type or print your answers legibly. The waiver application must be completed and signed by the treating physician – M.D. or D.O. **If primary care is obtained from physician's assistant or nurse practitioner, an M.D. or D.O. MUST also sign and provide state license number.**

This applicant is applying for a State diabetes waiver which would allow him/her to take insulin while operating a commercial motor vehicle (large truck or bus) in intrastate commerce (operations in Colorado only). A large part of the application process is your evaluation to determine if this individual has any medical problem related to diabetes that might impair safe driving.

1. I am familiar with the patient's 3-year health history (select all that apply)
 - a. As the treating physician;
 - b. Through a records review; and/or
 - c. Consultation with the treating physician.

If patient's history is not known or available, do not continue your evaluation.

2. Date of initial diagnosis of diabetes mellitus: _____
3. Is the patient responsible for management of his/her disease: **YES** **NO**
4. Insulin Usage:
 - a. Date insulin use began: _____
 - b. Does the driver have stable control of his/her diabetes using insulin? **YES** **NO**
 - c. Date of Patients Most Recent Exam _____
 - d. Date of last A1C test _____ Result _____

Physician's Name: _____

Address: _____

Phone: _____ State License Number _____

- ❖ I hereby certify that in my medical opinion, this applicant understands, and is able and willing to manage their diabetes mellitus. **YES** **NO**
- ❖ I hereby certify that in my medical opinion, the applicant is able to safely operate a commercial motor vehicle (CMV) in intrastate commerce (Colorado only) while using insulin. **YES** **NO**

Length of time this Diabetes Waiver should be good for? (Cannot be more than 2 years) _____

Restrictions, if any: _____

Physician's Signature: _____ Date: _____

RETURN TO: COLORADO STATE PATROL-MOTOR CARRIER, ATTN: MEDICAL WAIVERS, 15075 SOUTH GOLDEN ROAD, GOLDEN, CO 80401

FOR COLORADO STATE PATROL WAIVER PROGRAM USE ONLY		
APPLICATION REVIEWED BY (PRINT)	DATE	EFFECTIVE AND EXPIRATION DATES (IF APPROVED)