Easy DOT Exam
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DOT Medical Clearance: HYPERTROPHIC CARDIOMYOPATHY

*If the driver **meets** the above requirements and your recommendation is that the driver can operate a CMV safely, please sign and date below.*

_____ _____

Provider's Signature ***Date***

Please return this letter to our office by fax to: _____

*If the driver **does not meet** the above requirements and your recommendation is that the driver **cannot** operate a CMV safely, please sign and date below.*

_____ _____

Provider's Signature ***Date***

Please return this letter to our office by fax to: _____

*If the driver **does not meet** the above requirements **and it is your opinion that the driver should be allowed** to drive a commercial vehicle, DOT medical examiners may use discretion if there is sufficient medical reasoning for why the guidelines should not be followed. Should this be the case, please identify in the area below which guideline is not met, and the medical reason the driver is safe to drive.*

_____

_____

_____

_____ _____

Provider's Signature ***Date***

Please return this letter to our office by fax to: _____

Print name or affix stamp: _____

Address (City, State, Zip): _____

Thank you for your assistance.