

**VANDERBILT HEALTH AT MNPS HEALTH CARE CENTERS**

Fessey Court	2494 Fessey Court, Nashville, TN 37204	Phone (615) 259-8755	Fax (615) 244-0520
Stratton A	306 W Old Hickory Boulevard, Madison, TN 37115	Phone (615) 259-8755	Fax (615) 865-6360
Stratton B	306 W Old Hickory Boulevard, Madison, TN 37115	Phone (615) 259-8755	Fax (615) 868-3112
Two Rivers	2995 McGavock Pike, Nashville, TN 37214	Phone (615) 259-8755	Fax (615) 232-3865
Mt. View	3812 Murfreesboro Road, Antioch, TN 37013	Phone (615) 259-8755	Fax (615) 641-2280
West	655 Colice Jeanne Road, Nashville, TN 37221	Phone (615) 259-8755	Fax (615) 646-9190

**COMMERCIAL DRIVER CERTIFICATION DETERMINATION – VISION**

Exam Date \_\_\_\_\_  
 DOT Driver \_\_\_\_\_  
 DOB \_\_\_\_\_

The above individual has presented to the clinic for a Commercial Driver Fitness Determination in accordance with U.S. Code of Federal regulation 49 CFR 391.41. During the examination, the following was noted:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Driver Consent for Release of Medical Information

I, \_\_\_\_\_, hereby authorize the release to MNPS Health Care Centers for the following information.

- \_\_\_ All medical records and reports
- \_\_\_ Latest vision test
- \_\_\_ Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Print Name \_\_\_\_\_

Statement of Personal Physician

According to the U.S. Code of Federal Regulation Title 49 part CFR 391.41 (b)(10) states "A person is physically qualified to drive a commercial motor vehicle if that person: *Has distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70° in the horizontal Meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green, and amber*".

I have read the above and understand the regulation and guidelines cited. I verify that the above individual meets the specified vision standards.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Physician Print Name \_\_\_\_\_  
 Specialty \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE FAX TO OUR \_\_\_\_\_ LOCATION AT FAX NUMBER \_\_\_\_\_**