

998 Hospitality Way Suite A Aberdeen, MD 21001 **P**: 410.272.7700 **F**: 410.272.7707 **E**: [promptohc@gmail.com](mailto:promptohc@gmail.com)

*“Many bus and truck drivers have documented that “nervous trouble” related to neurotic, personality, emotional, or adjustment problems are responsible for a significant fraction of their preventable accidents. The degree to which an individual is able to appreciate, evaluate, and adequately respond to environmental strain and emotional stress is critical when assessing an individual’s mental alertness and flexibility to cope with the stresses of commercial motor vehicle driving.” 391.41 (b)(9)*

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\* The medical examiner at Prompt Occupational Healthcare is requesting the patient’s provider fill out the note below and send it back. This note will serve as a clearance regarding their medication and mental wellness for their DOT physical. If there are any questions or concerns, please feel free to contact us at the information listed above. \*

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**Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date)

(Patient/ Guardian/ Authorized Representative Signature)

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

(Relationship to Patient)

(Printed Guardian/ Authorized Representative Name)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The above listed patient authorizes the following healthcare facility to make record disclosure:**

**Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **P**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **F**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby state that the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is on medication that has shown to be adequate/ effective, safe, and stable and the nature and severity of their underlying condition does not interfere with safe driving.

(Patient Name)

(Provider Name PRINTED)

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date)

(Provider Signature)