



40-1505 R10/14 azdot.gov

Mail Drop 818Z
Medical Review Program
PO Box 2100
Phoenix AZ 85001-2100

ARIZONA INTRASTATE DIABETES WAIVER PROGRAM

Dear Applicant:

Thank you for your interest in the Arizona Intrastate Diabetes Waiver Program. The information in this letter and the accompany materials need to be read carefully. The applicant is responsible for providing all required information. The following information required to be submitted:

1. Applicant Information Checklist;
2. Signed copy of the Medical Examination Report (completed by the Medical Examiner);
3. Signed copy of the Medical Examiner's Certificate (completed by the Medical Examiner);
4. Endocrinologist Evaluation Checklist;
5. Vision Evaluation Checklist;

How does the applicant apply for a waiver from the Arizona Department of Transportation (ADOT) diabetes standard?

A. Medical Examiner

The applicant must be examined by a medical examiner, as defined in 49 CFR 390.5. The examiner can be a physician, (MD, DO), advanced nurse practitioner, physician assistant, or chiropractor if allowed by their state regulations to certify drivers. This examination **STARTS** the waiver process. The applicant **MUST** take the Certifying Medical Examiner Evaluation letter to the appointment with the medical examiner for him/her to review prior to performing the examination. In addition, the applicant must bring a copy of his/her 5 year medical history to the examination for the medical examiner to review. The medical examiner will have copies of the Arizona Department of Transportation Medical Examination Report Form and the Medical Examiner's Certificate. The applicant must meet all medical standards and guidelines, other than diabetes, in accordance with Arizona Administrative Code (AAC) R 17-5-208 and 49 CFR 391.41 (b) (1-13).

Other than the use of insulin to treat their diabetes, any other medical problem or condition that prevents the applicant from being certified by the medical examiner must be corrected **BEFORE** the rest of this application is completed. Therefore, the endocrinologist and vision evaluations **SHOULD NOT** be completed until the medical examiner certifies the applicant. The applicant must submit copies of the completed medical examination report and medical examiner's certificate. The certificate should indicate that the driver is certified **ONLY IF** the driver has a diabetes waiver. The certificate is not valid until the insulin waiver is obtained from the Arizona Diabetes Waiver Program.

B. Endocrinologist Evaluation Checklist

The applicant must be examined by a physician who is a board-certified or board-eligible endocrinologist. The applicant must take the Endocrinologist Evaluation Checklist and glucose logs to the appointment. The endocrinologist must complete all parts of the checklist. The applicant must submit the endocrinologist's signed letterhead, a completed checklist, and any additional reports outlined in the checklist to the waiver program.

C. Vision Evaluation Checklist

The applicant must have a vision examination by an ophthalmologist or optometrist. An applicant with **diabetic retinopathy MUST be evaluated by an ophthalmologist**. The applicant must take the Vision Evaluation Checklist to the appointment. The ophthalmologist or optometrist must complete all parts of the checklist. The applicant must submit the optometrist/ ophthalmologist's signed letterhead and a completed checklist to the waiver program.

Please note that both the Endocrinologist and Vision medical evaluations are only valid for 6 months from the date performed. The medical examiner's evaluation is valid for 1 year from the date performed. Applicants will be required to submit a new examination for any of the aforementioned examinations if they expire during the application process.

D. Additional Applicant Information

The applicant must provide a completed Applicant Information Checklist, a readable photocopy of both sides of the driver's license, and a current motor vehicle record.

Additional medical information may be required, based on review of the information submitted. Prior to submitting the application, please review all information and make sure that each checklist is **completely filled out and that all required information is included**. Application review will be delayed if the information submitted is not current or if it is incomplete. Mail all information to:

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The application may be faxed to 623-925-9323. However, original documents **must** be mailed to the above address.

What Happens After a Completed Application Is Submitted?

The Arizona Medical Review Program (AZMRP) will review the application and notify the applicant if additional information is required or missing. Please note, as stated above, that additional medical information may be required. Once the application is complete, the AZMRP will determine applicant eligibility for this program.

If granted, the Arizona Intrastate Diabetes Waiver is valid for CMV operation within Arizona only and does not exempt the applicant from other states requirements or foreign requirements, such as Canada and Mexico.

If the Applicant Does Not Meet Eligibility Criteria

If the AZMRP determines that the applicant does not meet program eligibility criteria, a decision letter will be mailed directly to the applicant outlining the reason that the Agency is unable to grant the waiver from the ADOT diabetes standard.

How Long Does the Process Take?

The AZMRP is required to complete the application process within 180 days from the date all required information is submitted by the applicant.

What Is Required of the Driver After a Waiver Is Granted?

The waiver certificate and requirements are sent to the exempted applicant by USPS mail. The AZMRP can issue a waiver for a maximum of 2 years. Quarterly and annual medical monitoring and reporting are conditions of the waiver from the ADOT diabetes standard of AAC R17-5-208 and 49 CFR 391.41(b) (3). The driver will receive the necessary forms from the AZMRP and will be responsible for compliance. Additionally, the driver is required to reapply for renewal every two years, and, as with monitoring, the responsibility of reapplication rests with the driver. The driver must have yearly medical re-certification examinations.

If you have questions related to the application process outlined in this document, please call
602-771-2460.

Sincerely yours,

Yvette Kinkade
Medical Review Program Supervisor

Applicant Checklist

1. Driver Information

Name (First, Middle Initial, Last):		
Street		
Address:		
City:	State:	Zip code:
Mailing Address, if different than above		
Street		
Address:		
City:	State:	Zip code:
Telephone number:		
Mobile phone number:		
Fax number:		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of birth (mm/dd/ yyyy)		
Driver License Number:		

2. Current Employment (if applicable)

Employer's name:		
Employer's		
Address:		
City:	State:	Zip code:
Employer's Telephone number:		
Do you currently drive for this employer? <input type="checkbox"/> YES <input type="checkbox"/> NO		

3. Driver License and Motor Vehicle Record

Medical Review Program will review your Arizona Driver License Motor Vehicle Record (MVR) for the past 39 months.

This request is to verify that you have a valid license and will not be used for any other purpose.

4. Statement of Qualification

Interstate Commerce is trade, traffic, or transportation involving the crossing of a State boundary. Either the vehicle, its passengers, or cargo must cross a State boundary, or there must be the intent to cross a State boundary to be considered an interstate carrier. Intrastate Commerce is trade, traffic, or transportation within a single State.

I intend to drive a CMV in:	<input type="checkbox"/> Interstate commerce only
	<input type="checkbox"/> Intrastate commerce only
Do you have any waivers, exemptions, or Skill Performance Evaluation certificates? (check one)	
<input type="checkbox"/> YES <input type="checkbox"/> NO	

If yes, list each, including date of issue, date of expiration, and identification number.

Name	Issue Date	Expiration Date	ID#

Prior to signing this statement, please review the Regulatory Criteria on Physical Qualifications for Commercial Drivers attached to the Endocrinologist Medical Evaluation Checklist.

By signing below, I allow the ADOT to review my MVR and I hereby certify that the following statement is true: "I acknowledge that I must be otherwise qualified under AAC R 17-5-208 and 49 CFR 391.41(b) (1-13) or hold a valid medical waiver before I can legally operate a CMV in intrastate commerce."

Signature: _____ Date _____

CERTIFYING MEDICAL EXAMINER EVALUATION GUIDELINES

ARIZONA INTRASTATE DIABETES WAIVER PROGRAM

The applicant is applying for an Arizona Intrastate diabetes waiver to allow insulin use while operating a commercial motor vehicle (large truck or bus) in intrastate commerce. Effective August 29, 2014, the driver is required to be examined by a medical examiner as part of the application process. A medical examiner is defined as an advanced practice nurse, doctor of chiropractic, doctor of osteopathy, medical doctor, or physician assistant who is licensed in their state to perform these examinations. This change will assist the Agency in determining that the individual is qualified for all medical standards, other than diabetes, in accordance with Arizona Administrative Code (AAC) R17-5-208 and 49 CFR 391.41(b); expedite the application process; and make the process consistent with other medical exemption and certificate programs, including the Skill Performance Evaluation program.

This examination begins the exemption process. The certifying medical examiner must review the applicant's 5 year medical history and provide the applicant with a completed Arizona Department of Transportation (ADOT) medical examination report and medical examiner's certificate. The applicant is responsible to submit copies of these forms with their application. The form and certificate are not valid until ADOT has issued an insulin waiver. Any other medical problem or condition that prevents being certified by the medical examiner must be corrected **BEFORE** the rest of this application is completed.

IT IS THE EXAMINER'S RESPONSIBILITY TO DETERMINE IF THE APPLICANT MEETS ALL MEDICAL STANDARDS AND GUIDELINES, OTHER THAN DIABETES, IN ACCORDANCE WITH 49 CFR 391.41 (B) (1-13).

IF THE APPLICANT PASSES THE CERTIFICATION EXCEPT FOR USING INSULIN:

Check the following on the Medical Examination Report:

- meets standards but periodic evaluation required
- due to "insulin use" driver qualified only for (check the 1 year box)
- accompanied by an "Arizona Intrastate diabetes" waiver/exemption

Check the following on the Medical examiner's Certificate:

- accompanied by an "Arizona Intrastate diabetes" waiver/exemption
- Medical examination expiration date should be one year from the date of examination.

The applicant is required to submit copies of the Medical Examination Report and Medical Examiner's Certificate along with the endocrinologist and the ophthalmologist/optometrist evaluation checklists, to be reviewed by Arizona Medical Review Program (AZMRP) for the determination of qualification for the Arizona intrastate diabetes waiver.

If you have questions, please call 602-771-2460.

Please print and sign your name below and return this to the applicant:

Medical Examiner's Name (please print): _____ Date: _____

Medical Examiner's Signature: _____



Motor Vehicle Division

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ENDOCRINOLOGIST EVALUATION ARIZONA INTRASTATE DIABETES WAIVER PROGRAM CHECKLIST

Driver Identifying Information

Name:(first, mi, last)	
Address: (city, state, zip code)	
DOB (mm/dd/yyyy)	AZ DL Number

This applicant is applying for an Arizona Intrastate diabetes waiver to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in intrastate commerce. Part of the application process is an evaluation by a board-certified or board-eligible Endocrinologist to determine if the individual has any medical problem related to diabetes that might impair safe driving.

The applicant's examination by an Endocrinologist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

- I am board certified in endocrinology
 I am eligible in endocrinology

If neither, do not continue your assessment. Applicants must be evaluated by an endocrinologist who is board-certified or board-eligible.

2. Office Telephone number: _____ Office Fax number: _____

3. Date of most recent examination:
(mm/dd/yyyy) _____

4. I am familiar with the patient's medical history for the past 5 years through a records review, treating the patient or consultation with the treating physician.

YES NO

A review of the applicant's 5 year medical history is required. If the history is not available, please state the reason.

5. Date of initial diagnosis of diabetes mellitus: _____

Treatment for diabetes mellitus prior to insulin use:

None Diet Oral agent

6. Insulin Usage:

Date insulin use began: _____

Type of insulin(s) and current dosage now used: _____

Length of time on current dose: _____

Is the applicant compliant with his/her insulin regimen? YES NO

If patient uses insulin pump, current average daily dose: _____

7. FMCSA defines a **severe hypoglycemic reaction** as one that results in:

Seizure, or

Loss of consciousness, or

Requiring assistance of another person, or

Period of impaired cognitive function that occurred without warning.

In the last 5 years, while being treated for diabetes, has the patient had recurrent (2 or more) severe hypoglycemic episodes? YES NO

In the last 12 months, while being treated for diabetes has the patient had a severe hypoglycemic episode? YES NO (if no proceed to #9 below)

If yes, provide information on each hypoglycemic episode:

Date(s): _____

Include additional information about each episode including symptoms of hypoglycemic reaction, treatment, and suspected cause:

Was the patient hospitalized? YES NO

If yes, provide brief summary of hospitalization:

Has the patient's treatment regimen changed since the last hypoglycemic episode

YES NO

Briefly explain changes:

8. Additional Information or History (if none, write none)

9. List all medications including those taken related to the treatment of diabetes (if none, write none)

Name of Medication	Dose	Reason for Taking The Medication

10. In your medical opinion, does any one of the listed medications have the potential to compromise the driver's ability to operate a CMV safely?

YES NO

If yes, which medication(s): _____

11. Associated Medical Conditions (please check yes or no):

- | | | |
|------------------------|---|--|
| Renal Disease | Renal insufficiency | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Proteinuria | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Nephrotic Syndrome | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cardiovascular Disease | Coronary artery disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Hypertension | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Transient ischemic attack | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Peripheral vascular disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Neurological Disease | Autonomic neuropathy(i.e., cardiovascular GI, GU) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Peripheral Neuropathy | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | If yes is check one below | |
| | <input type="checkbox"/> Sensory | |
| | <input type="checkbox"/> Decreased sensation | |
| | <input type="checkbox"/> Loss of vibratory sense | |
| | <input type="checkbox"/> Loss of position sense | |

If the applicant has been or is currently being treated for any of the above medical conditions, provide relevant additional information (consultation notes, special studies, follow-up reports, and hospital records).

12. Stable Insulin Regimen/Glucose Measurements:

A. Background and criteria:

The driver should have stable control and no risk of hypoglycemia and hyperglycemia while operation a CMV

30 day requirement: An individual diagnosed with diabetes mellitus who had been previously treated with oral medication, and who now requires insulin, should have at least a 1-month period on insulin to establish stable control.

60 day requirement: An individual newly diagnosed with diabetes mellitus, who is now starting insulin, should have at least a 2-month period on insulin to establish stable control.

B. Glucose Measurements:

A CMV driver should not have large fluctuations in blood glucose levels. The determination of a patient's stable control is left to the treating endocrinologist.

a. I have reviewed the patient's daily glucose monitoring logs while using insulin.

YES NO

b Does the patient have any large fluctuations that may impact safe driving?

YES NO

13. Since beginning insulin use, has the patient received education in the management of diabetes that includes diet, monitoring, recognition and treatment of hypoglycemia and hyperglycemia? YES NO

If yes, please provide last education date (mm, dd, yyyy)

Note: The applicant must participate in a diabetes education program at least annually to apply for and remain in the diabetes waiver program.

14. I hereby certify that in my medical opinion, this applicant understands how to individually manage and monitor his/her diabetes mellitus

YES NO

15. In my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage their diabetes.

YES NO

16. I hereby certify that in my medical opinion, the applicant is able to safely operate a commercial motor vehicle (large truck or motor coach) in intrastate commerce while using insulin.

YES NO

Printed name	Signature
License Number	Today's date
Date of Expiration	State of Issue



Motor Vehicle Division

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VISION EVALUATION
ARIZONA INTRASTATE
DIABETES WAIVER
PROGRAM CHECKLIST

Driver Identifying Information

Name:(first, mi, last)
Address: (city, state, zip code)
DOB (mm/dd/yyyy)

This applicant is applying for an Arizona Intrastate diabetes waiver to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in intrastate commerce. Part of the application process is an eye examination by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving.

Note: If the applicant has retinopathy, an ophthalmologist examination is required.

The applicant's examination by an ophthalmologist or an optometrist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

PLEASE CHECK/FILL IN REQUESTED INFORMATION

- 1. I am an ophthalmologist I am an optometrist
2. Office Telephone number: Office Fax number:
3. Date of most recent examination: (mm/dd/yyyy)

- 4. Distant Visual Acuity (please provide both if applicable)
UNCORRECTED CORRECTED
Glasses Contact Lens

Right eye: 20/ Left eye: 20/
Right eye: 20/ Left eye: 20/

- 5. Field of vision (FOV)*:
Please record the interpreted results in degrees of horizontal field of vision for each eye. The terms "normal" or "full" are not acceptable responses.

Right eye: degrees
Left eye: degrees
Test used to determine:

***Note:** If the patient has received laser treatment, and in your medical opinion you believe the patient's FOV is compromised, Arizona Medical Review Program (AZMRP) recommends formal perimetry to determine if the driver meets the FOV standard.

6. Color Vision:

Is the patient able to identify correctly the standard red, green, and amber traffic control signal color YES NO

Note: If color testing results are inconclusive, it is discretionary whether to administer a controlled test using an actual traffic signal to determine the individual's ability to recognize red, green, and amber.

An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).

7. Does the patient have diabetic retinopathy? YES NO

If yes: Proliferative
 Stable Unstable
 Non-proliferative
 Stable Unstable

Treatment: _____

Date diagnosed: _____

Surgery/procedures: _____

Requires recheck in _____ months

8. Does the patient have macular edema?
 YES NO

9. Does the patient have cataract(s)?
 YES NO

10. Does the patient have any other medical diagnosis related to vision?
 YES NO

If yes, what? _____

11. If yes to any of the conditions listed above, are any unstable?
 YES NO

If yes, which condition(s)? _____

12. In your medical opinion, is monitoring required more often than annually?
 YES NO

If yes, how often? _____

Printed name	Signature
License Number	Today's date
Date of Expiration	State of Issue