



MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

SPEC-F FORM (ENDOCRINOLOGIST CERTIFICATION)

CERTIFICATION BY ENDOCRINOLOGIST FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

MAIL COMPLETED FORM TO:	ATTN: MEDICAL EXEMPTION PROGRAM MOTOR CARRIER SERVICES P.O. BOX 893 JEFFERSON CITY, MO 65102-0893	IF ASSISTANCE NEEDED, CALL: 573-522-9001 OR Toll Free at 1-866-831-6277 FAX 573-522-4260
--------------------------------	--	--

SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT (To be completed by driver applicant.)

DRIVER-APPLICANT'S FULL NAME			MAIDEN/FORMER NAME(S)		
RESIDENCE ADDRESS			GENDER (PLEASE CHECK ONE BOX) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
CITY		STATE	ZIP		DATE OF BIRTH
(AREA CODE) HOME TELEPHONE # ()		(AREA CODE) WORK PHONE # (IF ANY) ()		SOCIAL SECURITY #	

SECTION 2. IDENTIFICATION OF ENDOCRINOLOGIST (To be completed by board-certified or board-eligible Endocrinologist.)

ENDOCRINOLOGIST'S BUSINESS NAME			BOARD CERTIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO		
ENDOCRINOLOGIST'S FULL NAME			BOARD ELIGIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO		
BUSINESS ADDRESS					
CITY		STATE		ZIP	
(AREA CODE) OFFICE TELEPHONE # ()		(AREA CODE) OFFICE FAX # ()		PROFESSIONAL CERTIFICATION #	
NAME OF CERTIFYING ORGANIZATION				PROFESSIONAL LICENSE #	
ADDRESS OF CERTIFYING ORGANIZATION					
CITY		STATE		ZIP	

SECTION 3. MEDICAL HISTORY (To be completed by board-certified or board-eligible Endocrinologist.)

THE COMPLETE MEDICAL EXAMINATION MUST CONSIST OF A COMPREHENSIVE EVALUATION OF THE APPLICANT'S MEDICAL HISTORY AND CURRENT STATUS WITH A REPORT INCLUDING THE FOLLOWING INFORMATION:

DATE INSULIN USE BEGAN		INSULIN TYPE AND DOSAGES		DIABETES TYPE (PLEASE CHECK ONE BOX) <input type="checkbox"/> TYPE 1 <input type="checkbox"/> TYPE 2	
A	WHAT IS THE APPLICANT'S CURRENT MEASURE OF GYLCOSYLATED HEMOGLOBIN (HGA1C)?			MEASUREMENT	
B	WHAT DATE WAS THE CURRENT MEASUREMENT TAKEN?			DATE OF MEASUREMENT	
C	WHAT DATE DID THE APPLICANT BEGIN USING INSULIN TO CONTROL HIS/HER DIABETES?		MONTH	DAY	YEAR
D	HOW LONG HAS THE APPLICANT BEEN USING INSULIN TO CONTROL HIS/HER DIABETES AND DRIVING A COMMERCIAL MOTOR VEHICLE?		MONTHS	DAYS	YEARS
E	HAS THE ENDOCRINOLOGIST PRESCRIBED A DIET TO BE UTILIZED FOR CONTROL OF THE APPLICANT'S DIABETES? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN:				

SECTION 3. MEDICAL HISTORY (To be completed by board-certified or board-eligible Endocrinologist.) (Continued)

F	LIST THE DATE(S) OF EACH AND EVERY HYPOGLYCEMIC REACTION OF THE APPLICANT WITHIN THE PAST FIVE YEARS, THAT EITHER:
1.	RESULTED IN THE APPLICANT'S LOSS OF CONSCIOUSNESS OR SEIZURE;
2.	REQUIRED THE APPLICANT TO OBTAIN THE ASSISTANCE OF ANOTHER PERSON;
3.	RESULTED IN IMPAIRED COGNITIVE FUNCTION THAT OCCURRED WITHOUT WARNING SYMPTOMS.

G	LIST ANY AND ALL SIGNIFICANT FACTORS: SMOKING, ALCOHOL USE, OTHER MEDICATIONS OR DRUGS TAKEN.

H	HAS THE ENDOCRINOLOGIST PERFORMED EXAMINATIONS ON THE APPLICANT TO DETECT ANY PERIPHERAL NEUROPATHY OR CIRCULATORY INSUFFICIENCY OF THE EXTREMITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN:

I	DOES THE ENDOCRINOLOGIST HAVE REPORTS OF ANY HYPOGLYCEMIC INSULIN REACTIONS WITHIN THE LAST FIVE YEARS? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLAIN:

CHECK EACH OF THE FOLLOWING BOXES TO CONFIRM COMPLETION

<input type="checkbox"/>	A DIABETES DIAGNOSIS AND DISEASE HISTORY ←CHECK BOX TO CONFIRM COMPLETION	<input type="checkbox"/>	HOSPITALIZATION RECORDS ←CHECK BOX TO CONFIRM COMPLETION
<input type="checkbox"/>	CONSULTATION NOTES FOR DIAGNOSTIC EXAMINATIONS ←CHECK BOX TO CONFIRM COMPLETION	<input type="checkbox"/>	FOLLOW UP REPORTS ←CHECK BOX TO CONFIRM COMPLETION
<input type="checkbox"/>	SPECIAL STUDIES PERTAINING TO THE DIABETES ←CHECK BOX TO CONFIRM COMPLETION		

SECTION 4. EXAMINING ENDOCRINOLOGIST

A	IS THE ENDOCRINOLOGIST FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY FOR THE PAST FIVE YEARS THROUGH ACTUAL TREATMENT OVER THAT TIME?
<input type="checkbox"/> YES - HOW LONG?	<input type="checkbox"/> NO EXPLAIN:

SECTION 4. EXAMINING ENDOCRINOLOGIST (Continued)

B	IS THE ENDOCRINOLOGIST FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY FOR THE PAST FIVE YEARS THROUGH CONSULTATION WITH A PHYSICIAN WHO HAS TREATED THE APPLICANT DURING THAT TIME?		
----------	--	--	--

<input type="checkbox"/> YES	PHYSICIAN'S NAME	BUSINESS ADDRESS	
CITY	STATE	ZIP	(AREA CODE) BUSINESS TELEPHONE # ()

NO - EXPLAIN:

C	IN YOUR PROFESSIONAL OPINION, HAS THE APPLICANT BEEN EDUCATED IN DIABETES AND ITS MANAGEMENT, THOROUGHLY INFORMED OF AND UNDERSTANDS THE PROCEDURES WHICH MUST BE FOLLOWED TO MONITOR AND MANAGE HIS/HER DIABETES AND WHAT PROCEDURES SHOULD BE FOLLOWED IF COMPLICATIONS ARISE?
----------	--

YES NO EXPLAIN:

D	IN YOUR PROFESSIONAL OPINION, DOES THE APPLICANT HAVE THE ABILITY AND HAS HE/SHE DEMONSTRATED WILLINGNESS TO PROPERLY MONITOR AND MANAGE HIS/HER DIABETES?
----------	--

YES NO EXPLAIN:

SECTION 5. ENDOCRINOLOGIST CERTIFICATION AND VERIFICATION.

I CERTIFY THAT, IN MY MEDICAL OPINION, THE APPLICANT'S DIABETES DEFICIENCY IS STABLE AND HE/SHE IS CAPABLE OF PERFORMING THE DRIVING TASKS REQUIRED TO OPERATE A COMMERCIAL MOTOR VEHICLE, AND THAT THE APPLICANT'S CONDITION WILL NOT ADVERSELY AFFECT HIS/HER ABILITY TO OPERATE A COMMERCIAL MOTOR VEHICLE SAFELY. YES NO

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

ENDOCRINOLOGIST'S NAME (Printed)	
ENDOCRINOLOGIST'S SIGNATURE	DATE SIGNED: