# TNC MEDICAL EXAMINATION REPORT

FORM: MER-TNC-1

| 1. DRIVER'S INFORMATION | | Driver Completes this Section | | | | |
|---|---|---|---|---|---|---|
| **Driver's Name(Last, First, Middle)** | | **Birthdate M/D/Y** | **Age** | **Sex** Male ☐ Female ☐ | **New Certification** ☐ **Recertification** ☐ **Follow-up** ☐ | **Date of Exam** |
| **Address** | **City, State, Zip** | **Work Tel:** ( ) **Home Tel:** ( ) **Cell Tel:** ( ) | | | | |

**2. HEALTH HISTORY** — **Driver Completes this Section**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| | | Any illness or injury in the last 5 years | | | Lung disease, emphysema, asthma, chronic bronchitis | | | Fainting, dizziness |
| | | Head/Brain injuries, disorders or illness | | | Kidney disease, dialysis | | | Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring |
| | | Seizures, epilepsy | | | | | | |
| | | ☐ Medication: _____ | | | Liver disease | | | Stroke or paralysis |
| | | Eye disorders or impaired vision (except corrective lenses) | | | Digestive problems | | | Missing or impaired hand, arm, foot, leg, finger, toe |
| | | Ear disorders, loss of hearing or balance | | | | | | |
| | | Heart disease or heart attack; other cardiovascular condition | | | Diabetes or elevated blood sugar controlled by: | | | Spinal injury or disease |
| | | ☐ Medication: _____ | | | ☐ Diet | | | Chronic low back pain |
| | | Heart surgery (valve replacement/bypass, angioplasty, pacemaker) | | | ☐ Pills<br>☐ Insulin | | | Regular, frequent alcohol use |
| | | High blood pressure | | | Nervous or psychiatric disorders, e.g. severe depression | | | Narcotic or habit forming drug use |
| | | ☐ Medication: _____ | | | ☐ Medication: _____ | | | |
| | | Muscular disease | | | Loss of, or altered consciousness | | | |
| | | Shortness of breath | | | | | | |

For any "Yes" answer, indicate onset date, diagnosis, and any current limitation. List all medications (including over-the-counter medications) used regularly or within the past 45 days.

_____

_____

_____

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature: _____ Date: _____

**Medical Examiner's Comments on Health History** (The medical examiner must review and discuss with the driver any "Yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below. )

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Driver's Name: _____ Date of Examination: _____

| Yes | No | **Physical Examination – Medical Examiner completes this Section**<br>*If any of the following condition are present, include notes on whether the condition may be controlled such that the driver can transport passengers in a TNC motor vehicle safely with described restriction(s).* |
|---|---|---|
| ☐ | ☐ | **Loss of Limb or Limb Impairment:** Does this person have a defect, loss of limb or impairment which interferes with the ability to perform normal tasks associated with operating a motor vehicle? |
| | | |
| ☐ | ☐ | **Diabetes:** Does this person have an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control likely to interfere with his/her ability to control and drive a motor vehicle safely?<br>Notes: |
| | | |
| ☐ | ☐ | **Cardiovascular Condition:** Does this person have a current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure, and that is likely to interfere with his/her ability to control and drive a motor vehicle safely?<br>Notes: |
| | | |
| ☐ | ☐ | **Respiratory Dysfunction:** Does this person have an established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with his/her ability to control and drive a motor vehicle safely?<br>Notes: |
| | | |
| ☐ | ☐ | **Hypertension:** Does this person have an established medical history or clinical diagnosis of high blood pressure likely to interfere with his/her ability to control and drive a motor vehicle safely? *(See certification standards)*<br>Notes: |
| | | |
| ☐ | ☐ | **Rheumatic, Arthritic Orthopedic, Muscular, Neuromuscular, or Vascular disease:** Does this person have an established medical history or clinical diagnosis of rheumatic, arthritic orthopedic, muscular, neuromuscular, or vascular disease which interferes with his/her ability to control and drive a motor vehicle safely?<br>Notes: |
| | | |

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Driver's Name: _____ Date of Examination: _____

| Yes | No | **Physical Examination *(Continued)* – Medical Examiner completes this Section** |
|---|---|---|
| ☐ | ☐ | **Epilepsy:** Does this person have an established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control and drive a motor vehicle safely?<br>Notes: |
| | | |
| ☐ | ☐ | **Mental Disorders:** Does this person have a mental, nervous, organic, or functional disease or psychiatric disorder likely to interfere with his/her ability to drive a motor vehicle safely?<br>Notes: |
| | | |
| ☐ | ☐ | **Vision:** Does this person have a visual disorder or impairment resulting in acuity of worse than 20/40 (Snellen) in each eye without corrective lenses or corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity worse than 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision lower than 70° in the horizontal Meridian in each eye, and colorblindness resulting in the lack of an ability to recognize the colors of traffic signals and devices showing standard red, green, and amber?<br>Notes: |
| | | |
| ☐ | ☐ | **Drug Use:** Does this person use controlled substances prohibited in Colorado? The use of controlled substances are prohibited unless prescribed by a licensed medical practitioner who is familiar with the driver's medical history and has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a motor vehicle.<br>Notes: |
| | | |
| ☐ | ☐ | **Alcoholism:** Does this person have a current clinical diagnosis of alcoholism?<br>Notes: |
| | | |

**Physical Examination:**

A physical examination is required. A driver shall not be medically certified if, upon physical examination, the medical examiner determines that any of the conditions set forth in the examination requirements exist and cannot be controlled such that the driver can drive a motor vehicle safely.

**Loss of Limb:**

A person is physically qualified to be a TNC driver if that person has no loss of limb or limb impairment that will interfere with their ability to perform normal tasks associated with operating a motor vehicle.

**Diabetes:**

A person is physically qualified to be a TNC driver if that person has no established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If the condition can be controlled by the use of oral medication and diet, then an individual may be qualified under the present rule.

**Cardiovascular Condition:**

A person is physically qualified to be a TNC driver if that person has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure, and that is likely to interfere with his/her ability to control and drive a motor vehicle safely.

**Respiratory Dysfunction:**

A person is physically qualified to be a TNC driver if that person does not have an established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with his/her ability to control and drive a motor vehicle safely.

**Hypertension**:

A driver's blood pressure at the time of examination dictates the duration of his or her medical certification.

- A person may not be physically qualified to be a TNC driver if his or her blood pressure exceeds 179/109.
- A person may be physically qualified to be a TNC driver for a two year period if his or her blood pressure is less than 140/90.
- A person may be physically qualified to be a TNC driver for a one-year period if his or her blood pressure is in the following range: 140-159/90-99.
- A person may receive a one-time certificate for 3 months if his or her blood pressure is in the following range: 160-179/100-109.

**Vision**:

Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.

The use of corrective lenses should be noted on the TNC Medical Examiner's Certificate.

**Drug Use:**

A person is physically qualified to be a TNC driver if that person does not use any drug or controlled substance unless prescribed by a licensed medical practitioner who is familiar with the driver's medical history and has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a motor vehicle.

**Alcoholism:**

A person is physically qualified to be a TNC driver if that person has no current clinical diagnosis of alcoholism.

# MEDICAL EXAMINER'S CERTIFICATE

FORM: MER-TNC-1

Driver's Name: _____ Date of Examination: _____

I certify that I am a doctor of medicine or osteopathy, a physician assistant, nurse practitioner, or clinical nurse specialist working under the direct supervision of a physician. I have examined _____. Based upon all circumstances known to me, I certify as follows:

☐ This person is medically fit to drive for a transportation network company without condition.

☐ This person is medically fit to drive for a transportation network company, subject to the condition(s) listed below.

_____

☐ This person is medically fit to drive for a transportation network company, only if accompanied by a _____waiver (i.e. PUC Vision Waiver, etc). In my medical opinion, based upon all circumstances known to me including the medical condition(s) requiring an accompanying waiver, the established medical history or clinical diagnosis is not likely to interfere with the person's ability to control and drive a motor vehicle safely for a Colorado transportation network company.

☐ This person is NOT medically fit to drive AND should NOT be issued a medical waiver.

***The term of the certification is based on certification requirements and the medical examination. This certification is for a term of 2 (two) years from the date of issuance unless an earlier expiration date is specified here:***

☐ 1 Year ☐ 6 Months ☐ Other: _____

The information I have provided regarding this examination is true and complete. A complete form with any attachments embodies my findings completely and correctly, and is on file in my office.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Medical Examiner | Telephone | Date of Issuance |
| _____ | _____ | _____ |
| Name of Medical Examiner (Print) | Medical License No./Issuing State | Title |

A copy of this Medical Examiner's Certificate must be kept on the driver's person at all times that the named driver is providing transportation network company services.