



☐ New Patient ☐ Existing Patient

☐ Scan ID ☐ Scan Phys ☐ Email

DOT – CDL PHYSICAL INTAKE FORM

Date: ____/____/____

Date of Birth: ____/____/____

First Name: _____ Last Name: _____

Current Street Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: (____) ____ - _____ Email: _____

Company Name: _____ Company Contact Name: _____

Company Phone: (____) ____ - _____ Company Email: _____

How did you hear about us? ☐ Google ☐ Employer ☐ Billboard ☐ Road Sign ☐ Other: _____

1. Do you have or are you applying for a Commercial Drivers License or Permit? ☐ Yes ☐ No

2. Do you own and operate your own trucking company subject to DOT regulations? ☐ Yes ☐ No

3. Would you like us to report your new medical certificate to your employer? ☐ Yes ☐ No

If you answer yes to this question, please provide company contact information above.

PROVIDING INACCURATE MEDICAL HISTORY OR OMITTING MEDICAL HISTORY ON A FEDERAL MEDICAL EXAMINATION MAY RESULT IN IMMEDIATE DISQUALIFICATION OF YOUR MEDICAL CERTIFICATE AND REPORTED TO THE FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION AND DMV.

4. Has your medical certificate ever been denied or issued for less than 2 years? ☐ Yes ☐ No

5. Have you ever had surgery? If yes, please list and explain below. ☐ Yes ☐ No

6. Are you currently taking medications (prescription, over the counter, supplements)? ☐ Yes ☐ No

If "yes", please list:

Terms & Conditions:

I authorize Carolina Drug and Alcohol Testing Services, LLC, to release a copy of my completed medical exam and medical examiner's certificate to my company or their designated service provider. I attest that the information provided on this intake form is factual and true to the best of my knowledge. I further agree and understand that this certificate and/or status is reported to the FMCSA National Registry and state DMV at the completion of the exam. I understand that the exam fee, regardless of the examiner's determination, is not refundable once the examination has begun.

Signature of Driver _____

Date _____

OFFICE USE ONLY

☐ Cash ☐ Credit Card Last 4# _____

☐ **INVOICE:** _____

OFFICE USE ONLY

Medical Certificate Issued?:

☐ YES Expires: ____/____/____

☐ NO ☐ DQ ☐ DP

6.26

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