NEW YORK STATE OF OPPORTUNITY. Department of Motor Vehicles

MEDICAL EXAMINATION REPORT OF DRIVER UNDER ARTICLE 19-A

DS-874 (6/15)

INSTRUCTIONS TO MEDICAL EXAMINER: The complete standards and instructions for conducting this examination are found in Section 6.10 of the Commissioner's Regulations, 15NYCRR6, and can be found at http://www.dmv.ny.gov/art19.htm. They are also available from the driver's carrier named below or from the Bus Driver Unit. **For New/Initial Examinations and Recertification**–review/complete **ALL** items on the form and sign where indicated on last page. **For Follow-up Examinations**–complete **ONLY** those items which require follow-up information and/or evaluation from a prior examination. Sign the form where indicated. If additional space is required for further comments and information, use form DS-874C, and attach it to this form.

1 DRIVER/CARRIER INFORMATION *(to be completed by the driver and/or driver's carrier)*

Driver's Last Name	First	M.I.	Date of Birth (Month/Day/Year)	Age	Sex ☐ Male ☐ Female

Street Address	City	State	Zip Code

Client/License ID Number (from Driver License)	State	Class of Driver's License	Endorsements	Restrictions	Expiration Date

Carrier/DBA Name	Legal Name (if different)	19-A Business ID Number

2 HEALTH HISTORY *(to be completed by the driver and reviewed by the medical examiner)*

Yes	No	
☐	☐	Any illness or injury in the last 5 years?
☐	☐	Head/Brain injuries, disorders or illnesses
☐	☐	Seizures, epilepsy
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack; other cardiovascular condition
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
☐	☐	High blood pressure
☐	☐	Muscular disease
☐	☐	Shortness of breath
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis

Yes	No	
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar controlled by *(check all that apply)*: ☐ diet ☐ insulin ☐ other medication
☐	☐	Incident of hyperglycemic or hypoglycemic shock
☐	☐	Loss of, or altered consciousness
☐	☐	Fainting, dizziness
☐	☐	Nervous or psychiatric disorders, e.g., severe depression
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, obstructive sleep apnea, loud snoring

Yes	No	
☐	☐	Stroke or paralysis
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain
☐	☐	Regular, frequent alcohol use
☐	☐	Narcotic or habit forming drug use
☐	☐	Tuberculosis
☐	☐	Other _____

For any YES answer, the driver should indicate the condition, onset date, diagnosis, treating medical examiner's name and address, and any current conditions or comments here: _____

List all medications (including over-the-counter medications) used regularly or recently. _____

☐ ***Additional comments/medications on attached DS-874C***

I certify that the above information and any other information on any accompanying DS-874C, if used, is complete and true. I understand that inaccurate, false or missing information may invalidate this examination.

➧ _____ _____

(Driver's Signature) (Date)

Medical Examiner's Comments: _____

TESTING (SECTIONS 3 THROUGH 8 TO BE COMPLETED BY THE MEDICAL EXAMINER)

3 VISION

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	FIELD OF VISION
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors. ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing corrective lenses. ☐ Yes ☐ No Monocular Vision. ☐ Yes ☐ No

Complete next two lines only if vision testing is done by an ophthalmologist or optometrist.

Date of Examination _____ Name of Ophthalmologist or Optometrist (print) _____ Telephone Number _____

License Number/State of Issue _____ ➧ _____ (Signature of Examiner)

4 BLOOD PRESSURE/PULSE RATE

Standard: If the blood pressure is consistently above 160/90 mm. Hg., further testing may be necessary to determine whether the driver is qualified to operate a bus. Numerical reading must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure Readings	1) Systolic/Diastolic	2) Systolic/Diastolic

Pulse Rate: ☐ Regular ☐ Irregular **Record Pulse Rate:** _____

Date of Examination

Driver's Name: Last _____ First _____ MI _____ Driver's License/Client ID #_____

5 HEARING Standard: **a)** Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or **b)** average hearing loss in better ear ≤ 40 dB

☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

a) Record distance in feet from individual at which forced whispered voice can first be heard.

Right ear	\Feet	Left ear	\Feet

OR

b) If audiometer is used, record hearing loss in decibels.(acc. to ANSI Z24.5-1951)

Right Ear			Left Ear		
500Hz	1000 Hz	2000 Hz	500Hz	1000 Hz	2000 Hz
Average:			Average:		

6 LABORATORY AND OTHER TEST FINDINGS -

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. Other Testing (Describe and record):

URINE SPECIMEN

SP. GR	PROTEIN	BLOOD	SUGAR

7 PHYSICAL EXAMINATION ***(to be completed by the medical examiner)*** **- Height _____ (in.) Weight _____ (lbs.)**

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for.

BODY SYSTEM	CHECK FOR:	Yes*	No	BODY SYSTEM	CHECK FOR:	Yes*	No
1. General appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse	☐	☐	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness	☐	☐
2. Eyes	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	☐	☐	8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins	☐	☐
				9. Genito-urinary System	Hernias.	☐	☐
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums	☐	☐	10. Extremities- Limb impaired.	Loss or impairment of leg, foot, toe, arm, hand, finger, perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.	☐	☐
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.	☐	☐				
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	☐	☐	11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness	☐	☐
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/ or xray of chest	☐	☐	12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski reflexes, ataxia.	☐	☐

*** MEDICAL EXAMINER'S COMMENTS:** _____

_____

_____

_____ ☐ ***Additional comments on attached DS-874C.***

8 MEDICAL EXAMINER'S CERTIFICATION: ☐ **New/Initial Certification** ☐ **Recertification** ☐ **Follow-Up**

I certify that I have examined (*Print Driver's Full Name*)_____ in accordance with the Commissioner's Regulations and with knowledge of the driver's duties. In accordance with Commissioner's Regulation 6.10, I find:

☐ the person named above is physically or medically qualified.

☐ the person named above **IS NOT** physically or medically qualified because_____

☐ the person named above is physically or medically qualified with **Restrictions and/or Follow-up** as detailed below:

- ☐ Qualified only when wearing corrective/contact lenses.
- ☐ Qualified - Certification required every six months for **diabetic condition**.
- ☐ Qualified only when wearing a hearing aid.
- ☐ Qualified only by use of prosthetic devices or equipment modifications. Description/Type: _____
- ☐ Qualified, other: _____

REMARKS: _____ ☐ ***Additional comments on attached DS-874C.***

Print name and check title of: _____ Date: _____

☐ Examining Physician
☐ Nurse Practitioner
☐ Physician Assistant
☐ Advanced Practice Nurse*
(who is not a Nurse Practitioner)

Signature of Examiner: _____

Address of Examiner: _____

License or Certificate No./Issuing State _____

* If the examination is conducted by an Advanced Practice Nurse, who is not a Nurse Practitioner, the Supervising Physician must certify as follows:
I certify that the individual who conducted the above examination was acting under my direction and supervision and, if applicable, in accordance with a written practice or protocol agreement.

Print _____ _____ _____
(Name of Supervising Physician) (Signature of Supervising Physician) License or Certificate No./Issuing State

THE CARRIER MUST KEEP THE ORIGINAL EXAMINATION REPORT (NOT A PHOTOCOPY) IN THE EMPLOYEE'S 19-A FILE ANY PHOTOCOPIES MUST IDENTIFY THE LOCATION OF THE ORIGINAL

reset/clear