

MAY 15 2012
by
State Corporation Commission
of Kansas

**THE STATE CORPORATION COMMISSION
OF THE STATE OF KANSAS**

Before the Commissioners: Mark Sievers, Chairman
 Ward Loyd, Commissioner
 Thomas E. Wright, Commissioner

In the Matter of the Investigation of **John C. Tipton,**)
of Meriden, Kansas, Regarding the Violation of the)
Motor Carrier Safety Statutes, Rules and Regulations,)
and the Commission's Authority to Impose Penalties,) Docket No. 12-TRAM-656-PEN
Sanctions and/or the Revocation of Motor Carrier)
Authority)

DIRECT TESTIMONY

OF

MIKE HOEME

ON BEHALF OF

THE STATE CORPORATION COMMISSION

OF THE STATE OF KANSAS

May 15, 2012

1 **Q. Please state your name.**

2 A. Mike Hoeme.

3 **Q. By whom, and in what capacity, are you employed?**

4 A. I am the Director of the Transportation Division of the Kansas Corporation
5 Commission (KCC or Commission).

6 **Q. Please summarize your educational and professional background.**

7 A. I have a bachelor's degree in business. My professional background is directly
8 related to safety compliance in the Transportation industry. Prior to joining the
9 Commission, I worked for a private motor carrier as its Safety Compliance Director
10 (1985-2000). My responsibilities were to oversee the company's safety program,
11 including compliance with motor carrier statutes and regulations.

12 In 2000, I accepted a position with the Commission as Public Service Administrator
13 in its Transportation Division. In 2001, I accepted the position of Transportation
14 Division Director. In this capacity, I oversee the Commission's Transportation
15 Division and am responsible for implementation and enforcement of the
16 Commission's motor carrier safety program.

17 In 2004, I was elected by my peers to the Executive Committee for the National
18 Conference of State Transportation Specialists. Overall, I have more than twenty
19 years experience in the transportation industry.

20 **Q. Have you previously testified before this Commission?**

21 A. Yes.

22 **Q. What is the purpose of your testimony in this proceeding?**

1 A. The main purpose of my testimony is to address concerns raised by Mr. Tipton in his
2 request for hearing challenging the March 16, 2012, Penalty Order issued against
3 John C. Tipton of Meriden, Kansas.

4 **Q. What is your understanding of Mr. Tipton's reasons for requesting this hearing?**

5 A. It appears from his request for hearing that Mr. Tipton is contesting the fine amount
6 for the violations discovered during the February 21, 2012, compliance review of
7 John C. Tipton, conducted by KCC Transportation Division Special Investigator
8 Verna Jackson. Mr. Tipton also notes in his request for hearing that he was not
9 adequately provided with information relevant to his unique position as a local owner
10 operator. A true and correct copy of Mr. Tipton's request for hearing is attached
11 hereto as "Hoeme Attachment A."

12 **Q. In Mr. Tipton's request for hearing, he refers to his "unique position of being a**
13 **local owner operator." Could you please explain some of the unique aspects of**
14 **Mr. Tipton's position as a local owner operator?**

15 A. I believe Mr. Tipton is referring to the applicability of an exemption from the
16 Commission's operating authority requirement, found at K.S.A. 2011 Supp. 66-1,109,
17 based on the nature of his operations hauling gravel and/or rock. However, this
18 situation—where safety regulations still apply to the carrier even though it is not
19 required to obtain operating authority—is not a unique position within the motor
20 carrier industry in Kansas. The majority of motor carriers in Kansas are small owner-
21 operators, operating only one to two trucks, and many of these carriers are exempt
22 from the Commission's operating authority requirement for any number of reasons.

23 **Q. Please explain this Commission's jurisdiction as it relates to motor carriers.**

1 A. K.S.A. 2011 Supp. 66-1,111, provides that “no public motor carrier of property or
2 passengers or private motor carrier of property or local cartage carrier shall operate
3 any motor vehicle for the transportation of either persons or property on any public
4 highway in this state except in accordance with the provisions of this act, and
5 amendments thereto, and other applicable laws.” K.S.A. 2011 Supp. 66-1,108(g)
6 defines a “motor vehicle” as any automobile, truck, trailer, semitrailer, tractor, motor
7 bus or any other self-propelled or motor-driven vehicle used upon any of the public
8 highways of the state for the purpose of transporting persons or property.
9 Furthermore, K.S.A. 66-1,108(i) defines “private motor carrier” as a person who
10 provides transportation of property or passengers, by commercial motor vehicle and is
11 not a for-hire motor carrier.

12 **Q. How is a “commercial motor vehicle” defined?**

13 A. A “commercial motor vehicle” is defined in 82-4-1(d) as any of the following: (1) A
14 vehicle that has a gross vehicle weight rating or gross combination weight rating, or a
15 gross vehicle weight or gross combination weight, of 4,536 kg (10,001 pounds) or
16 more, whichever is greater; (2) a vehicle designed or used to transport more than
17 eight passengers, including the driver, for compensation; (3) a vehicle that is
18 designed or used to transport more than 15 passengers, including the driver, and is not
19 used to transport passengers for compensation; or (4) a vehicle used in transporting
20 material found by the secretary of transportation to be hazardous under 49 U.S.C.
21 §5103 and transported in a quantity requiring placarding according to regulations
22 prescribed by the secretary under 49 C.F.R. Part 172 as adopted in K.A.R. 82-4-20.

1 **Q. Mr. Hoeme, based on the information in this docket, do you believe John C.**
2 **Tipton of Meriden, Kansas, is a motor carrier subject to Commission authority?**

3 A. Yes.

4 **Q. To what Commission motor carrier rules and regulations is John C. Tipton**
5 **subject?**

6 A. Mr. Tipton's motor carrier operation is subject to Commission safety regulations,
7 including Federal Motor Carrier Safety Regulations of general applicability, driver
8 qualification files regulation, drug and alcohol testing regulations, hours of service
9 regulations, and inspection, repair and maintenance regulations.

10 **Q. Does John C. Tipton have Commission authority to operate?**

11 A. Not currently. Mr. Tipton had previously obtained Private Operating Authority on
12 December 21, 2009. This authority was cancelled on January 24, 2011 for failure to
13 renew.

14 **Q. What requirements did Mr. Tipton have to fulfill prior to receiving Private**
15 **Operating Authority in 2009?**

16 A. In addition to the application and application fee for Private Operating Authority, a
17 carrier must provide documentation relevant to commodities hauled, designation of
18 agent, balance/income statement information, proof of insurance, motor vehicle
19 records, and proof of attendance at a Commission-sponsored safety seminar.

20 **Q. Did Mr. Tipton attend a Commission-sponsored safety seminar in 2009?**

21 A. Yes. Mr. Tipton attended a seminar on behalf of John C. Tipton on December 21,
22 2009.

23 **Q. What information is covered in these safety seminars?**

1 A. These meetings provide detailed information to motor carriers in the areas of state
2 and FMCSA Safety Regulations for both intrastate and interstate travel, vehicle size
3 and weight information and related requirements, and information concerning IFTA
4 (International Fuel Tax Agreement) and IRP (International Registration Plan).

5 **Q. Mr. Hoeme, for the sake of clarification, is Mr. Tipton required to have**
6 **operating authority for his current operations.**

7 A. No. Under K.S.A. 2011 Supp. 66-1,109, Mr. Tipton is not required to have operating
8 authority based on the fact that he hauls rock and/or gravel.

9 **Q. Mr. Hoeme, is it the Transportation Staff's policy to recommend civil penalties**
10 **to motor carriers prior to a showing that the carrier knew or should have known**
11 **that the motor carrier operations are subject to regulation?**

12 A. No. We first seek to educate a carrier about the regulations if we have reason to
13 believe the motor carrier may not have known about the regulations. In this case, not
14 only did Mr. Tipton attend a Commission-sponsored safety seminar in 2009, but in
15 addition, I personally met with Mr. Tipton to discuss the regulations governing his
16 motor carrier operations and to assist him in obtaining compliance.

17 **Q. Can you tell us what all you discussed with Mr. Tipton, and what regulations**
18 **specific to his operation did you review with him?**

19 A. During her meeting with Mr. Tipton, SI Jackson requested my assistance with regard
20 to the applicability of the economic exceptions found at K.S.A. 2011 Supp. 66-1,109.
21 I discussed these exceptions with Mr. Tipton, and we determined he would be exempt
22 from the requirement to obtain Commission operating authority under K.S.A. 2011
23 Supp. 66-1,109(I). Then, I went over the Commission's safety regulations which

1 applied to John C. Tipton and assisted SI Jackson as she reviewed the compliance
2 manual with Mr. Tipton.

3 **Q. Based on your experience with the Commission policies and practices as it**
4 **applies to the issuance of civil penalties, do you believe the assessment of the**
5 **recommended civil penalties in the penalty order are fair and consistent with**
6 **Kansas law and Commission practices?**

7 A. Yes. The amounts assessed for the violations discovered during the compliance
8 review of John C. Tipton are standard amounts assessed for these violations.

9 **Q. Mr. Hoeme, is there anything else you would like to share that may aid the**
10 **Commission in making its decision in this matter?**

11 A. Yes. In his request for hearing, Mr. Tipton calls into question the quality of education
12 he received from Transportation Division of the KCC. However, his compliance
13 review with SI Jackson indicated John C. Tipton's compliance program to be in pretty
14 good shape, with these two noted exceptions. Mr. Tipton did possess a medical card,
15 though it had expired, which indicated he was aware of the requirement to be
16 medically certified as fit to operate a commercial motor vehicle. Failing to regularly
17 confirm drivers are medically examined and certified as fit to operate a commercial
18 motor vehicle, and failing to conduct annual inspections on commercial motor
19 vehicles are serious safety concerns which directly impact the safety of the motor
20 carrier and the safety of the motoring public.

21 **Q. Thank you, Mr. Hoeme. Does this conclude your testimony?**

22 A. Yes, it does.

23

**HOEME
ATTACHMENT "A"**

REQUEST FOR HEARING

March 20, 2012

Commissions Executive Director
1500 SW Arrow Head Road
Topeka, Kansas 66604

c/o Amber Whitlock

Received
on
MAR 30 2012
by
State Corporation Commission
of Kansas

12-TRAM-656-PEN

To The Commissioners:

The purpose of this letter is to contest penalties assessed to John C. Tipton in regard to the docket no. 12-tram-656-pen.

Per the notice of penalty assessment, there are several items related to "grounds upon relief are sought."

First, On December 21, 2009, when private operating authority was obtained, there was no mention of guidelines for local owner operator by the issuing agent of the KCC.

Second, at the commission sponsored motor carrier education meeting held on December 21, 2009, there was no discussion of the specific guidelines for local operators by the provided instructor.

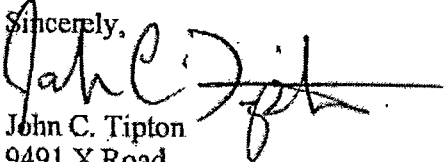
Third, during my Educational and Compliance review, my reviewer, Special Investigator, Verna Jackson, did not, herself, clearly understand the requirements for a local owner operator. Several times she had to refer to her supervisors and manuals to try to decipher exactly what was required of a company in my (John C. Tipton) unique position of being a local owner operator.

Lastly, during my Compliance Review, information that was not known by John C. Tipton, i.e., mileage driven per year and gross income, were arbitrarily assigned by Special Investigator Verna Jackson. This cavalier attitude in no way imparted the serious nature of these documents and procedures.

Although lack of knowledge is rarely a defensible position, I attended all training sessions in good faith that requirements for a local owner operator would be provided. There were several opportunities where I might have been given some sort of reminder of requirements but none was given. As a small businessman, struggling to manage all aspects of a complicated rule set and keep this business venture solvent, I feel that the amount of \$600 is excessive. In an attempt to rectify this situation, I have hand delivered all required documents to the KCC and have included copies with this letter.

It is my hope that the Commissioners can understand the oversight was not of a malicious intent but the result of a flawed system and lack of provided information. The assigned penalties would be devastating to the owner operator business, John C. Tipton. I welcome your further investigation into this matter and would be happy to make myself available for clarification as needed.

Sincerely,


John C. Tipton
9491 X Road
Meriden, KS 66512
785-554-5299

Phone: [REDACTED]

DATE: 3/18/2012
UNIT# 758 DRT
MILEAGE: 93

PREVENTATIVE MAINTENANCE SAFETY INSPECTION
CIRCLE TYPE OF SERVICE: "A" **"B"**

INSPECT ALL OF THE COMPONENTS BELOW AND MAKE NECESSARY CORRECTIONS.
REPAIR CODES: / = OK 0 = REPAIR REQUIRED X = REPAIR COMPLETED A B

- 1 CHANGE ENGINE OIL AND FILTERS: WATER/OIL SERVICE OIL BATH AIR CLEANER.
CHECK DRY-TYPE AIR CLEANER FOR RESTRICTION AND CHANGE IF NECESSARY
 - 2 CHANGE FUEL FILTER AND DRAIN FUEL/WATER SEPERATOR
 - 3 LUBRICATE CHASSIS ACCORDING TO VEHICLE LUBE CHART.
 - 4 CHECK TRANSMISSION AND DIFFERENTIAL OIL LEVELS; BREATHER VENTS & WHEEL SEALS
CHECK CLUTCH RELEASE BEARING & ADJUSTMENT, INSPECT BELL HOUSING & TRANS. BOLTS.
 - 5 CHECK ALL OIL, WATER, FUEL, AIR, AND EXHAUST LEAKS. PRESSURIZE COOLING SYSTEM.
 - 6 CHECK COOLANT LEVEL IN RADIATOR. RECORD ANTIFREEZE PROTECTION -30 DEGREES.
 - 7 CHECK ALL BELTS FOR WEAR AND PROPER TIGHTNESS, AND WASH OUT RADIATOR IF NEEDED.
CHECK DRIVELINE, U-JOINTS, AND TWO-SPEED MOTOR (FILL WITH 10W OIL)
 - 8 LUBRICATE ALL ACCELERATOR LINKAGE, SHUTTERSTAT LINKAGE, DOOR HINGES.
 - 9 LUBRICATE LOCKS, LATCHES, WINDOW REGULATORS AND CHECK ALL CAB GLASS.
 - 10 CHECK TIRES FOR DAMAGE, UNUSUAL WEAR, VALVE CAPS, AND INFLATE TO PROPER SPECS.
- | POS | REMARKS AND 32 | 0% POS | REMARKS AND 32 | 0% POS | REMARKS AND 32 | 0% |
|---------|----------------|--------|----------------|--------|----------------|----|
| L STEER | | LOF | | ROF | | |
| R STEER | | LIF | | RIF | | |
| | | LOR | | ROR | | |
| | | LIR | | RIR | | |
- 11 ADD 1 PINT "NAL CAL" TO COOLING SYSTEM EVERY COMPLETE SERVICE. CATERPILLER ONLY)
 - 12 TEST BATTERY CONDITION: ELECTROLYTE LEVEL, CLEAN ALL TERMINALS AND HOLD DOWNS.
 - 13 CHECK OIL LEVEL IN FRONT WHEELS. CHECK FOR WHEEL CRACKS AND LOOSE NUTS.
 - 14 LUBRICATE FOOT VALVE.
 - 15 CHECK BRAKES, BRAKE HOSES AND BRAKE ADJUSTMENT. DRAIN AIR TANKS
 - 16 CHECK SPRINGS, U-BOLTS, AND STEERING LINKAGE FOR DEFECTS.
 - 17 CHECK FAN HUB AND BLADES FOR CRACKS, OR DEFECTS.
 - 18 INSURE PROPER OPERATION OF ALL LIGHTS, INSTRUMENTS, GUAGES, DEFROSTER, HEATER, HORN
 - 19 CHECK WINDSHIELD WIPERS, AND SAFETY EQUIPMENT IN CAB. CLEAN CAB AREA
 - 20 COMPLETE DECAL AND PLACE ON LEFT DOOR JAMB
 - 21 HAVE FORMAN SIGN OFF DRIVER VEHICLE INSPECTION REPORT IF ATTACHED TO WORK ORDER.

THIS INSPECTION HAS BEEN COMPLETED AND UNIT IS ROAD READY
PERFORMED BY Joan C. Tipton

PREPARED FOR:
Joan C. Tipton.

Vertical column of handwritten checkmarks and "NA" on the right side of the inspection list.

ANNUAL REPORT OF VEHICLE INSPECTION

As prescribed in 49CFR 396.17 through 396.23 and Appendix G to subchapter B

49CFR 396.21

"(b) (1) The original or a copy of the inspection report shall also be retained by the motor carrier under whose control the vehicle operates for 30 consecutive days or more, for a period of 1 year. The inspection report shall be retained where the vehicle is either housed or maintained.

(b) (2) The original or a copy of the inspection report shall be maintained on the vehicle and available for inspection upon demand of an authorized Federal, State or local official."

Description of Vehicle: Make Ford Year 1981 Model 700
 Vehicle Identification No. [REDACTED]
 Type: Tractor Dump Truck Trailer — Semi-Trailer —
 License plate No. [REDACTED] State KS
 Owner's Name John C. Tipton
 Name of Authorized Carrier John C. Tipton

Indicate in the proper column the result of the inspection of each item listed:

ITEM	NOT DEFECTIVE	DEFECTIVE	DESCRIPTION OF DEFECT
Brake System	X		
Coupling Devices	X		
Exhaust System	X		
Fuel System	X		
Lighting Devices	X		
Safe Loading	X		
Steering Mechanism	X		
Suspension	X		
Frame	X		
Tires	X		
Wheels and Rims	X		
Windshield Glazing	X		
Windshield Wipers	X		

Any other items requiring attention: NONE

I hereby certify that on the 18 day of MARCH, at 1:00 PM, I carefully inspected the driver's log and equipment described above and that this is a true and correct report of the result of such inspection.

John C. Tipton
(Name of person making inspection) (type or print)

[Signature]
(Signature of person making inspection)

I hereby certify that on the date stated above the person who make the inspection covered by this report was competent and qualified to make such inspection and was duly authorized to make such inspection as a representative of

John C. Tipton
(Name of authorized carrier)

Date 3/18/2012

[Signature]
(Signature of authorized carrier or co-partner or officer of authorized carrier)

MEDICAL EXAMINER'S CERTIFICATE

Name of Examinee: John L. A. Tola

Examination Station: at residence with Dr. Hilary Miller

City: Washington, D.C.

State: D.C.

Date of Examination: 3/15/19

Signature of Examinee: [Signature]

Signature of Medical Examiner: [Signature]

Name of Medical Examiner: Dr. Hilary Miller D.C.

Address of Medical Examiner: [Redacted]

City: Washington, D.C.

State: D.C.

Date of Issuance: 3/15/19

Expiration Date: 3/15/20

Remarks: [Redacted]

Signature of Applicant: [Redacted]

Name of Applicant: [Redacted]

Address of Applicant: [Redacted]

City: Washington, D.C.

State: D.C.

Date of Application: 3/15/19

Signature of Applicant: [Redacted]

Name of Applicant: [Redacted]

Address of Applicant: [Redacted]

City: Washington, D.C.

State: D.C.

Date of Application: 3/15/19

Signature of Applicant: [Redacted]

Name of Applicant: [Redacted]

Address of Applicant: [Redacted]

City: Washington, D.C.

State: D.C.

Date of Application: 3/15/19

Signature of Applicant: [Redacted]

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Date of Application: 3/15/19

Signature of Applicant: [Redacted]

Name of Applicant: [Redacted]

Address of Applicant: [Redacted]

City: Washington, D.C.

State: D.C.

Date of Application: 3/15/19

Signature of Applicant: [Redacted]

Name of Applicant: [Redacted]

Address of Applicant: [Redacted]

City: Washington, D.C.

State: D.C.

Date of Application: 3/15/19

Signature of Applicant: [Redacted]

Name of Applicant: [Redacted]

Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

1. DRIVER'S INFORMATION <small>Driver completes this section</small>							
Driver's Name (Last, First, Middle) <i>T. BROWN JOHN C</i>		Social Security No. [REDACTED]	Birthdate [REDACTED]	Age [REDACTED]	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	New Certification <input type="checkbox"/> Recertification <input checked="" type="checkbox"/> Follow-up <input type="checkbox"/>	Date of Exam <i>3/15/12</i>
Address [REDACTED]		City, State, Zip Code [REDACTED]	Work Tel: () [REDACTED]	Driver License No. [REDACTED]	License Class <input checked="" type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> Other	State of Issue [REDACTED]	

2. HEALTH HISTORY <small>Driver completes this section, but medical examiner is encouraged to discuss with driver.</small>																																																																																																																																				
<table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Any illness or injury in the last 5 years?</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Head/Brain injuries, disorders or illnesses</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Seizures, epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="2">□ medication _____</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Eye disorders or impaired vision (except corrective lenses)</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Ear disorders, loss of hearing or balance</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Heart disease or heart attack; other cardiovascular condition</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="2">□ medication _____</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Heart surgery (valve replacement/bypass, angioplasty, pacemaker)</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">High blood pressure □ medication _____</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Muscular disease</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Shortness of breath</td></tr> </table>	Yes	No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Any illness or injury in the last 5 years?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Head/Brain injuries, disorders or illnesses		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Seizures, epilepsy		<input type="checkbox"/>	<input type="checkbox"/>	□ medication _____		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses)		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Ear disorders, loss of hearing or balance		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition		<input type="checkbox"/>	<input type="checkbox"/>	□ medication _____		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)		<input type="checkbox"/>	<input checked="" type="checkbox"/>	High blood pressure □ medication _____		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Muscular disease		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Shortness of breath		<table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Long disease, emphysema, asthma, chronic bronchitis</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Kidney disease, dialysis</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Liver disease</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Digestive problems</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Diabetes or elevated blood sugar controlled by:</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="2">□ diet</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="2">□ pills</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="2">□ insulin</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Nervous or psychiatric disorders, e.g., severe depression</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="2">□ medication _____</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Loss of, or altered consciousness</td></tr> </table>	Yes	No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Long disease, emphysema, asthma, chronic bronchitis		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney disease, dialysis		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Liver disease		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Digestive problems		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes or elevated blood sugar controlled by:		<input type="checkbox"/>	<input type="checkbox"/>	□ diet		<input type="checkbox"/>	<input type="checkbox"/>	□ pills		<input type="checkbox"/>	<input type="checkbox"/>	□ insulin		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Nervous or psychiatric disorders, e.g., severe depression		<input type="checkbox"/>	<input type="checkbox"/>	□ medication _____		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Loss of, or altered consciousness		<table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Fainting, dizziness</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Stroke or paralysis</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Missing or impaired hand, arm, foot, leg, finger, toe</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Spinal injury or disease</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Chronic low back pain</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Regular, frequent alcohol use</td></tr> <tr><td><input type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr> <tr><td colspan="2">Narcotic or habit forming drug use</td></tr> </table>	Yes	No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fainting, dizziness		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stroke or paralysis		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Spinal injury or disease		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chronic low back pain		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Regular, frequent alcohol use		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Narcotic or habit forming drug use	
Yes	No																																																																																																																																			
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Any illness or injury in the last 5 years?																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Head/Brain injuries, disorders or illnesses																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Seizures, epilepsy																																																																																																																																				
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□ medication _____																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Eye disorders or impaired vision (except corrective lenses)																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Ear disorders, loss of hearing or balance																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Heart disease or heart attack; other cardiovascular condition																																																																																																																																				
<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																			
□ medication _____																																																																																																																																				
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Heart surgery (valve replacement/bypass, angioplasty, pacemaker)																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
High blood pressure □ medication _____																																																																																																																																				
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Muscular disease																																																																																																																																				
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Shortness of breath																																																																																																																																				
Yes	No																																																																																																																																			
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Long disease, emphysema, asthma, chronic bronchitis																																																																																																																																				
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Kidney disease, dialysis																																																																																																																																				
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Liver disease																																																																																																																																				
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Digestive problems																																																																																																																																				
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Diabetes or elevated blood sugar controlled by:																																																																																																																																				
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□ pills																																																																																																																																				
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□ insulin																																																																																																																																				
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Nervous or psychiatric disorders, e.g., severe depression																																																																																																																																				
<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																			
□ medication _____																																																																																																																																				
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Loss of, or altered consciousness																																																																																																																																				
Yes	No																																																																																																																																			
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Fainting, dizziness																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Stroke or paralysis																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Missing or impaired hand, arm, foot, leg, finger, toe																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Spinal injury or disease																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Chronic low back pain																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Regular, frequent alcohol use																																																																																																																																				
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																			
Narcotic or habit forming drug use																																																																																																																																				
<p>For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.</p> <p>_____</p> <p>_____</p>																																																																																																																																				

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 *John C. Brown* Date *3/15/12*

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.)

TESTING (Medical Examiner completes Section 3 through 7) Name: Last, TIPTON First, JOHN Middle, CAEB

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.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. **Monocular drivers are not qualified.**

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/20	Right Eye 180°
Left Eye	20/	20/20	Left Eye 180°
Both Eyes	20/	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

Monocular Vision: Yes No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination _____ Name of Ophthalmologist or Optometrist (print) _____ Tel. No. _____ License No./ State of Issue _____ Signature _____

4. HEARING

Standard: a) Must first perceive forced whispered voice \geq 5 ft., with or without hearing aid, or b) average hearing loss in better ear \leq 40 dB
 Check if hearing aid used for tests. Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

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

Right ear	Left Ear
5 Feet	5 Feet

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

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

5. BLOOD PRESSURE/ PULSE RATE

Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure	Systolic	Diastolic
	120	76

Driver qualified if \leq 140/90.

Pulse Rate: Regular Irregular

Record Pulse Rate: 80 bpm

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if \leq 140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if \leq 140/90
\geq 180/110	Stage 3	6 months from date of exam if \leq 140/90	6 months if \leq 140/90

6. LABORATORY AND OTHER TEST FINDINGS

Numerical readings must be recorded.

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR

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) _____

7. PHYSICAL EXAMINATION

Height: 5' 7 1/2" (in.) Weight: 150 (lbs.)

Name: Last, TOTON First, John Middle, Charles

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. See Instructions to the Medical Examiner for guidance.

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.		X	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		X
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.		X	8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		X
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.	X		9. Genito-urinary System	Hernias.		X
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.	X		10. Extremities-Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	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.		X
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	X		11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		X
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.	X		12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		X

*COMMENTS: _____

Note certification status here. See Instructions to the Medical Examiner for guidance.

- Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
- Does not meet standards
- Meets standards, but periodic monitoring required due to _____
- Driver qualified only for: 3 months 6 months 1 year Other

Temporarily disqualified due to (condition or medication): _____

Return to medical examiner's office for follow up on _____

- Wearing corrective lense
- Wearing hearing aid
- Accompanied by a _____ waiver/ exemption. Driver must present exemption at time of certification.
- Skill Performance Evaluation (SPE) Certificate
- Driving within an exempt intracity zone (See 49 CFR 391.62)
- Qualified by operation of 49 CFR 391.64

Medical Examiner's signature: [Signature]
 Medical Examiner's name: Dr. H. J. Currie
 Address: Meriden, CT
 Telephone Number: 785-484-3311

If meets standards, complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)

STATE OF KANSAS)
) ss.
COUNTY OF SHAWNEE)

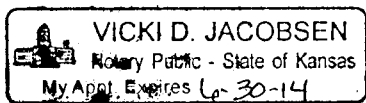
VERIFICATION

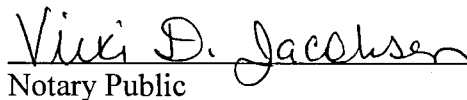
Mike Hoeme, being duly sworn upon his oath deposes and says that he is the Director of the Transportation Division of the Kansas Corporation Commission of the State of Kansas, that he has read and is familiar with the foregoing *Direct Testimony*, and that the statements contained therein are true and correct to the best of his knowledge, information and belief.



Mike Hoeme
Director
Transportation Division
State Corporation Commission of
The State of Kansas

Subscribed and sworn to before me this 15th day of May, 2012.





Notary Public

My Appointment Expires: June 30, 2014

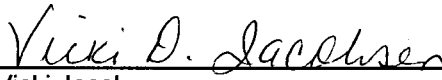
CERTIFICATE OF SERVICE

12-TRAM-656-PEN

I, the undersigned, hereby certify that a true and correct copy of the above and foregoing Direct Testimony was placed in the United States mail, postage prepaid, or hand-delivered this 16th day of May, 2012, to the following:

John C. Tipton, OWNER
John C. Tipton
9491 X Rd
Meriden, KS 66512-9454

AMBER SMITH, LITIGATION COUNSEL
KANSAS CORPORATION COMMISSION
1500 SW ARROWHEAD ROAD
TOPEKA, KS 66604-4027
Fax: 785-271-3354
a.smith@kcc.ks.gov
Hand Delivered



Vicki Jacobsen