

REQUEST FOR HEARING

2012.03.30 16:56:26
Kansas Corporation Commission
/s/ Patrice Petersen-Klein

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.

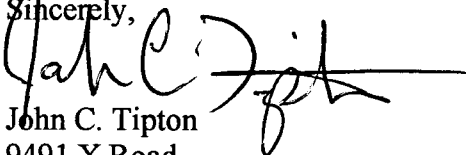
Third, during my Educational and Compliance review, my reviewer, Special Investigator, Verna Jackson, did not, herself, clearly understand the requirements for a local owner operator. Several times she had to refer to her supervisors and manuals to try to decipher exactly what was required of a company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

PREPARED FOR:

JOHN C. TIPTON

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. XXXXXXXXXX
 Type: Tractor DUMP TRUCK Trailer Semi-Trailer
 License plate No. 258 DRT 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) [Signature] (Signature of authorized carrier or co-partner or officer of authorized carrier)

Date 3/18/2012

MEDICAL EXAMINER'S CERTIFICATE

John Lipton

in accordance with the Motor Vehicle Code, Chapter 45, Sections 4501.01 through 4501.05, and the rules promulgated thereunder.

- wearing corrective lenses
- wearing hearing aid
- accompanied by a _____
- other than an exempt steady zone (49 CFR 391.403)
- accompanied by a 3rd Performance Evaluation Certificate (PE3)
- accompanied by operation of 49 CFR 391.44

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

Signature of Medical Examiner

P.C.

Date 3/15/14

Medical Examiner's Name (Print)
Dr. Al Currie D.C.

- MD DO
- Physician Assistant
- Chiropractor
- Advanced Practice Nurse

Medical Examiner's License or Certificate No./Issued State
01-05807-1 Kansas

Signature of Driver
[Redacted]

Medical Certificate Expiration Date
3/15/14

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 <i>KS</i>

2. HEALTH HISTORY <small>Driver completes this section, but medical examiner is encouraged to discuss with driver.</small>																																																																																																																																								
<table border="0" style="width: 100%;"> <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</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">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		<input type="checkbox"/>	<input type="checkbox"/>	medication _____		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Muscular disease		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Shortness of breath		<table border="0" style="width: 100%;"> <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">Lung 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"/>	Lung 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" style="width: 100%;"> <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																																																																																																																																							
<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																																																																																																																																								
<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																							
medication _____																																																																																																																																								
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																							
Muscular disease																																																																																																																																								
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																							
Shortness of breath																																																																																																																																								
Yes	No																																																																																																																																							
<input type="checkbox"/>	<input checked="" type="checkbox"/>																																																																																																																																							
Lung 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																																																																																																																																								
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																																																																																																																																								
<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> <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 _____

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.)

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 5 Feet	Left Ear 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 120	Diastolic 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.

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

Height: 5'7 1/2" (in.) Weight: 150 (lbs.) Name: Last, TROTTON First, John Middle, CARLES

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. A. Currie
 Address: Meriden
 Telephone Number: [Redacted]

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.)