Certification of Treating Provider for Use of Controlled Substances by a Commercial Motor Vehicle Driver/Operator

Dear Doctor,

Your patient, _____DOB:_____ is being evaluated for certification as a commercial motor vehicle driver/operator. This form will need to be completed in its entirety in order for us to consider this driver for a medical clearance, including initialing and signing the sections below. Please note that even with your clearance, we may not be able to certify a driver using prescribed narcotics or sedatives.

We will need the following:

1. **A record of prescription fills/refills over the last 12 months.**
2. **A list of all controlled substances prescribed by you over the last 12 months.**
3. **Your certification below about controlled medication use.**

Please initial each section A or section B below:

Section A:

_____ I have reviewed the Colorado Prescription Drug Monitoring Data Base and I certify that to the best of my knowledge, this driver is not obtaining controlled substances from any other provider.

_____This driver is on stable or decreasing doses of controlled substance medications.

_____This driver reports no driving while taking controlled substances.

_____This driver is showing no signs of medication abuse.

_____This driver is showing no signs of wake period sedation.

_____This driver is taking no more than 50 mg morphine equivalents per day if a narcotic is being taken.

_____This driver is not operating a vehicle for at least 8 hours after use of a short acting narcotic, or 12 hours if a long acting narcotic is taken.

_____I certify that I feel this driver is safe to operate a commercial motor vehicle, recognizing that this is a safety sensitive position requiring cognitive and physical skills, with important public safety risks.

_____I feel the medications and dosages prescribed by me are safe to be used by a commercial driver.

Section B:

_____I certify that this driver is no longer taking any controlled medications that might cause sedation.

_____I certify that I feel this driver is safe to operate a commercial motor vehicle, recognizing that this is a safety sensitive position requiring cognitive and physical skills, with important public safety risks.

Signature of Provider _____ Date: _____

Name of Provider (please print clearly) _____

Office Address:

_____

Office Phone Number: _____-_____-_____