



## BACKGROUND SCREENING REPORT

**P.O. Box 458**  
**New Port Richey, FL 34656**  
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**Toll Free: (800) 771-7703**  
<http://www.applicantinsight.com>

**SUBJECT NAME: Consumer, Jonathan**  
**SOCIAL SECURITY #: 000-00-0001**  
**LOCATION: Sales Training Demo Account**  
**CLIENT ID: S2006-00-0000**  
**REQUEST DATE: 08/11/2008**

### **Confidential Information Enclosed**

Information in this Consumer Report must be held in utmost confidence and there must be strict procedures maintained by the recipient to secure information against unauthorized third party access or use.

Information contained in this report is obtained from sources deemed reliable, though the accuracy of the information is not guaranteed. Human error in compiling this information is possible. Reasonable procedures will be followed to ensure the accuracy of information and reinvestigation will be conducted upon request. The Fair Credit Reporting Act requires specific procedures if adverse action is taken, in whole, or in part based upon the information contained in this report.

**Physical Examination Results**

|  |   |
|--|---|
| Date of Exam: <b>8/1/2008</b>                | Type of Exam: <b>DOT Physical</b>                                 |
| Reason for Test: <b>DOT Re-Certification</b> | Result: <b>Meets Standards / Qualifies for 2 Year Certificate</b> |
| Comments:                                    |   |

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**Medical Examination Report  
FOR COMMERCIAL DRIVER FITNESS DETERMINATION**

649-F (6045)

**1. DRIVER'S INFORMATION** Driver completes this section

|  |   |                                    |  |   |   |                                 |
|--|---|------------------------------------|--|---|---|---------------------------------|
| Driver's Name (Last, First, Middle)<br><i>Consumer, Jonathan</i> | Social Security No.<br><i>000-00-0001</i>     | Birthdate<br><i>01/01/67</i>       | Age<br><i>42</i>                       | Sex<br><input checked="" type="checkbox"/> M<br><input type="checkbox"/> F  | New Certification<br>Recertification Follow-up<br><input checked="" type="checkbox"/> | Date of Exam<br><i>08/01/08</i> |
| Address<br><i>123 Apple Ct.<br/>PPR, FL 34656</i>                | City, State, Zip Code<br><i>PPR, FL 34656</i> | Work Tel:<br><i>(813) 555-1212</i> | Driver License No.<br><i>C67905468</i> | License Class<br><input type="checkbox"/> A<br><input type="checkbox"/> B<br><input checked="" type="checkbox"/> C<br><input type="checkbox"/> D<br>Other | State of Issue<br><i>FL</i>   |                                 |
| Home Tel:<br><i>787 555-1234</i>                                 |   |                                    |  |   |   |                                 |

**2. HEALTH HISTORY** Driver completes this section, but medical examiner is encouraged to discuss with driver.

|   |   |  |
|---|---|--|
| Yes No<br><input checked="" type="checkbox"/> Any illness or injury in the last 5 years?<br><input checked="" type="checkbox"/> Head/Brain injuries, disorders or illnesses<br><input checked="" type="checkbox"/> Seizures, epilepsy<br><input type="checkbox"/> medication _____<br><input checked="" type="checkbox"/> Eye disorders or impaired vision (except corrective lenses)<br><input checked="" type="checkbox"/> Ear disorders, loss of hearing or balance<br><input checked="" type="checkbox"/> Heart disease or heart attack; other cardiovascular condition<br><input type="checkbox"/> medication _____<br><input checked="" type="checkbox"/> Heart surgery (valve replacement/bypass, angioplasty, pacemaker)<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Muscular disease<br><input type="checkbox"/> Shortness of breath | Yes No<br><input type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis<br><input checked="" type="checkbox"/> Kidney disease, dialysis<br><input checked="" type="checkbox"/> Liver disease<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Digestive problems<br><input type="checkbox"/> Diabetes or elevated blood sugar controlled by:<br><input type="checkbox"/> diet<br><input type="checkbox"/> insulin<br><input type="checkbox"/> other medication _____<br><input type="checkbox"/> Nervous system disorders, e.g., severe depression<br><input type="checkbox"/> Loss of consciousness | Yes No<br><input type="checkbox"/> Fainting, dizziness<br><input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring<br><input type="checkbox"/> Stroke or paralysis<br><input type="checkbox"/> Missing or impaired hand, arm, foot, leg, finger, toe<br><input type="checkbox"/> Spinal injury or disease<br><input type="checkbox"/> Chronic low back pain<br><input type="checkbox"/> Regular, frequent alcohol use<br><input type="checkbox"/> Narcotic or habit forming drug use |
|---|---|--|

For any YES answer, indicate onset date, diagnosis, treating physician's name, address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

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: *[Signature]* Date: *08/01/08*

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.)

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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/       | Right Eye <input type="checkbox"/> |
| Left Eye  | 20/         | 20/       | Left Eye <input type="checkbox"/>  |
| 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

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) \_\_\_\_\_ Title No. \_\_\_\_\_ License No./ State of Issue \_\_\_\_\_ Signature \_\_\_\_\_

4. **HEARING** Standard: a) Must first perceive forced whispered voice at 20 feet, with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB

**INSTRUCTIONS:** To convert audiometric test results from ISO to ANSI, -14 dB from ISO to ANSI, -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 |         |         |          |
|---|-----------|---------|---------|----------|----------|---------|---------|----------|
|   | 500 Hz    | 1000 Hz | 2000 Hz | Average: | 500 Hz   | 1000 Hz | 2000 Hz | Average: |
| b) If average hearing loss is recorded, record hearing loss in decibels (acc. to ANSI Z24.5-1951) |           |         |         |          |          |         |         |          |

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 | Reading         | Category | Expiration Date                       | Recertification  |
|---|----------|-----------|-----------------|----------|---------------------------------------|--|
| Driver qualified if ≤140/90.  |          |           | 140-159/90-99   | Stage 1  | 1 year                                | 1 year if ≤140/90. One-time certificate for 3 months if 141-159/91-99. |
| Pulse Rate: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular |          |           | 160-179/100-109 | Stage 2  | One-time certificate for 3 months.    | 1 year from date of exam if ≤140/90                                    |
| Record Pulse Rate: _____  |          |           | >180/110        | Stage 3  | 6 months from date of exam if ≤140/90 | 6 months if ≤ 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: \_\_\_\_\_ (in.) Weight: \_\_\_\_\_ (lbs.) Name: Last, First, Middle,

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* |    | BODY SYSTEM                      | CHECK FOR:  | YES* |    |
|--|--|------|----|----------------------------------|---|------|----|
|  |  | YES  | NO |                                  |   | 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 other eye conditions. Refer to ophthalmologist if appropriate. |      |    | 8. Vascular System               | Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.   |      |    |
| 3. Ears  | Scarring of tympanic membrane, occlusion of external canal perforated eardrums.  |      |    | 9. Genito-urinary System         | Hernias.  |      |    |
| 4. Mouth and Throat                                  | Irreparable deformities likely to interfere with breathing, swallowing.  |      |    | 10. Extremities-Limb             | 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. |      |    |
| 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's reflexes, ataxia.  |      |    |

\*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): \_\_\_\_\_  
 Medical Examiner's signature \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

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.)

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined Jonathan Consumer In accordance with the Federal Motor Car-  
rier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when:

- wearing corrective lenses
- wearing hearing aid
- accompanied by a \_\_\_\_\_ after exemption
- driving within an exempt intracity zone (49 CFR 391.62)
- accompanied by a Skill Performance Evaluation Certificate (SPE)
- Qualified by operation of 49 CFR 391.64

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

SIGNATURE OF MEDICAL EXAMINER

*[Signature]*

TELEPHONE

(813) 555-1222

DATE

8/1/08

MEDICAL EXAMINER'S NAME (PRINT)

DR. # Sloan

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

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE

FL 34658

SIGNATURE OF DRIVER

*[Signature]*

DRIVER'S LICENSE NO.

1C9905468

STATE

FL

ADDRESS OF DRIVER

123 Apple Ct NPR FL 34656

MEDICAL CERTIFICATE EXPIRATION DATE

08/01/10

**SAMPLE**