MRN:____________________

Date form is due: _______________

Acute MI and Coronary Artery Disease without CABG/PCI

Department of Transportation (DOT) regulations state that a person is qualified to operate a commercial motor vehicle after acute myocardial infarction provided there is "no exercise-induced myocardial ischemia or left ventricular dysfunction." Current regulations recommend the **driver be disqualified for 2 months** following an acute myocardial infarction.
Return to work certification is dependent upon examination and approval by the treating cardiologist, absence of ischemic symptoms, and tolerance of all cardiovascular medications. Satisfactory completion of an ETT to at least 6 METS without evidence of cardiac ischemia is required. Documentation of normal ventricular function (LVEF > 40%) is required for return to work after AMI.
Recertification is dependent upon examination and approval by the treating cardiologist, absence of ischemic symptoms, and tolerance of all cardiovascular medications every year.

Satisfactory completion of an ETT to at least 6 METS without evidence of cardiac ischemia is required at least every 2 years.

Full FMCSA guidelines are available electronically at: http://www.fmcsa.dot.gov/rulesregs/cardio.htm

Patient consent for release of Medical Information

I, ______________________________________hereby authorize the release of medical records and reports to Lancaster General Health Occupational Medicine.

Patient Signature______________________________________ Date_____________________
Date of Birth: ____________________________

Statement of Treating Physician

This patient had acute myocardial infarction on __________.

LVEF post MI ___________% (must be greater than 40%)

Please attach copy of negative exercise stress test with **documentation of exercise to 6 METS and no ischemic changes.** (required every 2 years)

I verify that this individual meets the criteria for operation of a commercial motor vehicle after AMI as described above. There is no imminent risk for syncope, adverse effects from medications or end organ damage that would likely affect ability to safely operate a commercial motor vehicle. This individual has received counseling with regards to the need for regular monitoring and has been compliant with recommendations for management.

Please list medications and dosages prescribed:

Physician Name/Signature_______________________________Date _____________________

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