MRN:____________________

Date form is due: _______________

Initial Return to Work
Coronary Artery Bypass Graft (CABG)

Department of Transportation (DOT) regulations state that a person is qualified to operate a commercial motor vehicle after coronary artery bypass grafting (CABG) if that person "has no clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse or congestive cardiac failure."

For individuals undergoing recent CABG, regulations recommend a three-month waiting period to allow for sternal healing. Certification is dependent upon examination and approval by the treating cardiologist 3 months after the CABG, asymptomatic, echocardiogram showing LVEF >40% and tolerance of all cardiovascular medications. Exercise tolerance test or equivalent should be performed at 5 years or annually thereafter; achievement of >6 METS without ischemia, dysrhythmias or elevated blood pressure is required for continued CMV certification.

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 CABG on (date)____________.

LVEF 3 months post CABG_________% (must be >40% to resume CMV operation)

Exercise tolerance test should be performed at 5 years and annually thereafter.

I verify that this individual meets the criteria for return to work after CABG 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 ______________________

Occupational Medicine
2110 Harrisburg Pike, Ste. 21 | PO Box 3200 | Lancaster, PA 17604-3200 | Phone (717) 544-3155
Secure Fax (717) 544-3167 | www.LancasterGeneralHealth.org/occmed