

MRN: \_\_\_\_\_

Date form is due: \_\_\_\_\_



**Percutaneous Coronary Intervention (PCI)  
Annual Recertification**

Department of Transportation (DOT) regulations state that a person is qualified to operate a commercial motor vehicle after PCI 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 PCI, recertification is dependent upon yearly 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 is recommended 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 PCI for \_\_\_\_\_ MI, \_\_\_\_\_ unstable angina, \_\_\_\_\_ stable angina on (date) \_\_\_\_\_.

Stress testing with documented workload capacity of > 6 METS without evidence of myocardial ischemia is required every 2 years after PCI in order to continue to operate a commercial motor vehicle.

**Please attach a copy of the most recent stress test.**

I verify that this individual meets the criteria for continued safe operation of a commercial motor vehicle 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 \_\_\_\_\_