MRN:	
Date form is due:	



ANTICOAGULATION

Department of Transportation (DOT) regulations permit operation of a commercial motor vehicle (CMV) while on anticoagulant medication (warfarin) as long as the anticoagulation has been controlled for at least one month as documented by stabilized International Normalized Ratios (INR's) appropriate for the condition being treated. CMV driver medical certification will emphasize the underlying medical condition(s), which require anticoagulation to determine if they pose a significant risk to safe operation of a CMV.

Patient Signature Date	CMV.		
I,hereby authorize the release of medical records and reports to Lancaster General Health Occupational Medicine. Patient Signature Date Date of Birth:	Patient consent for release of Medical Information		
Patient Signature Date Date of Birth:	,hereby authorize the release of medical records and reports to Lancaster General Health Occupational Medicine.		
	Patient Signature Date of Birth:	Date 	
Statement of Treating Physician	Statement of Treating Physician		
I verify that this individual's anticoagulation is under adequate control with an INR of	-	on is under adequate control with an INR of	
The INR has been under adequate control for (indicate length of time)		ol for (indicate length of time)	
Primary diagnosis requiring anticoagulation:	Primary diagnosis requiring anticoagulati	on:	
(Please include documentation of stable INR within the last 3 months)	(Please include documentation of	f stable INR within the last 3 months)	
This individual has received counseling with regards to the need for regular monitoring and has been compliant with scheduled testing at least monthly. Neither the underlying medical conditions, nor anticoagulation therapy, present an imminent risk that would likely affect ability to operate a commercial motor vehicle.	and has been compliant with scheduled t medical conditions, nor anticoagulation th	testing at least monthly. Neither the underlying herapy, present an imminent risk that would	
Physician Name/ SignatureDate	Physician Name/ Signature	Date	