Flathead Valley Community College
Commercial Driver's License Class
2025-2026

Class: CDL Professional Truck Driver

College Code: HEO 103

Length: 8 weeks

Total Cost: $3,323.60*
*Flathead and Lincoln County residents (based on 2024-2025 tuition rates, subject to change)

General Information

The course includes training for a class "A" CDL with up to 40 hours of one-on-one drive-time with an instructor. Students can choose additional endorsements for Passenger, Tanker, Doubles/Triples, and Hazmat as part of this course. Tuition and fees cover the cost of the Department of Transportation (D.O.T.) physical, Entry Level Driver Training (ELDT) training modules, the D.O.T. drug test, and drive time with instructors.

Fees do not cover the cost of the Class A license test (approximately $50).

Scholarships

While this program is not eligible for financial aid, students who demonstrate financial need may qualify for assistance.

- **Windmill Foundation scholarship**
  - Pick up an application at the Financial Aid Office or from the Trades Institute (TI) advisor after you have registered, but before the last week of class.
  - Write an essay describing your financial need and plans to use your CDL.
  - You may receive a maximum of $1260 toward the cost of the program.
  - Call the Financial Aid office at (406) 756-3849 for more information.
- **Job Service Kalispell**
  - Contact someone in "Programs" at Kalispell Job Service to see if you qualify for any of their programs. (406) 758-6200

Prerequisites

- At least 18 years old (18- to 20-year-olds can only drive in-state)
- Current Montana driver's license
- Birth certificate or Passport
- Proof of state residence
- No DUI's in the past five years

Classroom/ Instructor Info

216 Hutton Ranch Road
Mark Twichel, mtwichel@fvcc.edu
406-253-9750

Mike Mulcahy, mmulcahy@fvcc.edu
406-431-2373

Steps to Obtain a CDL

- **Apply to FVCC as a non-degree student.** It's free to apply. www.fvcc.edu/apply
- **Meet with the Trades Institute Advisor:** Gabe Dillon - gdillon@fvcc.edu - (406) 756-3893
- **Register** for HEO 103 using the "Add/Drop Form" and turn it in to the Admissions Office. Registration will utilize a paper add/drop form or an email exchange of the form with the student.
- **Pay** at least half the total cost for the program at the Business Office.
    - $200 will be non-refundable for the cost of the D.O.T. Physical and Drug Test.
    - You can pay with a card by calling (406) 756-3831. Payments can also be made in person; the Business Office is located in Blake Hall.
- **Schedule a D.O.T. Physical.** Once registered, make an appointment for your Dept. of Transportation physical at the FVCC Student Health Clinic. Phone: (406) 756-4331.
- **D.O.T. Physical Exam**
    - Read and fill out the paperwork before your appointment.
    - Bring your receipt of payment to your appointment in the Broussard Center room 136.
- **Drug test**
    - The instructors will schedule the written learner's permit test date and time.
    - Once you have passed the learner's permit test, you will receive a drug test kit and instructions from your instructor.

Class Schedule

- **First week:**
    - Class will meet the first two days from 8am to 3:30pm. Turn in the signature page for FVCC drug and alcohol policy to your instructor.
    - At the end of the week, go to the Department of Motor Vehicles (DMV) for the exam for a learner's permit. (Instructors work with DMV staff to schedule your learner's permit ahead of time.) https://dojmt.gov/driving/commercial-driver-licensing/
- **Weeks 2-8:**
    - Sign up to drive approx. 2 hours a day, Monday to Thursday with an instructor.
    - ELDT Module Training and Testing. Modules are assigned once 1-on-1 drive time begins and are completed via computer at home.
    - You will also learn backing skills, do pre-trip preparation, and practice in a driving simulator.
- **Last week:**
    - Pay the balance on your FVCC account before the final test.
    - Take one of FVCC's trucks to use for the D.O.T. drive test to get your CDL.

Frequently Asked Questions

When do you offer the CDL classes?

FVCC has six sessions of HEO 103 per calendar year: January, March, May, June, August, and October. Registration for these sessions opens well in advance of the class and usually fills within one week. Once a student is admitted to the college, they can make an appointment with the advisor to register. The

advisor registers students in the order they appear on the calendar and the calendar often fills well in advance of the registration date.

Class session	Registration opens	Calendar fills by
January	November	September/October
March	November	September/October
May	March	January/February
June	March	January/February
August	May	March/April
October	May	March/April

Do your trucks have automatic transmissions?

No, FVCC uses trucks with 10 and 13 speed manual transmissions. Class A CDL license holders can drive automatic transmissions, but Class A licenses for automatic-only transmissions cannot drive manual transmissions commercially.

I have a medical condition (diabetes, epilepsy, chronic pain, etc.). Will that prevent me from passing the D.O.T. physical?

It depends. Evaluations for D.O.T. physicals adhere to national standards and FVCC employees do not make those decisions. The best way to get an answer is to talk to your doctor.

I already have my D.O.T. medical card. Do I have to get another physical done?

No, if you already have your physical completed, you can bring your current paperwork to the class. However, if your card is set to expire soon, it may be worth getting the physical to push your renewal date out. There are no discounts given for students that already have the D.O.T. physical completed.

I already have my CDL learner's permit. Do I have to attend the first week of classes?

Please contact the CDL instructors. Students with D.O.T. physicals and CDL learner's permits can present their documentation to the instructors and receive the D.O.T. drug test. There are no discounts given for students that have already completed these steps.

My schedule says the class meets at the "QHUT". Where is that?

The CDL classroom and truck staging area is at 216 Hutton Ranch Road. While located on FVCC property, access to the Quonset hut is gained by driving past Walmart on Hutton Ranch Road. In the roundabout, there is a sign for 216 Hutton Ranch Road where you take a right. The CDL classroom is located just behind the Quonset hut to the east.

Why does it say, "up to 40 hours of one-on-one drive time"?

The CDL instructors make their assessment for student readiness based on the pre-trip inspection checklist, backing, and driving skills. If a student shows proficiency in all three areas, instructors will make the recommendation to take the CDL driving test.

If I fail a portion of the driving test, do I have to take the entire thing again?

No, you only need to retest on the portions of that you did not pass.

Flathead Valley Community College
Kalispell, MT 59901

CONTROLLED (CHEMICAL) SUBSTANCE AND ALCOHOL USE & POSSESSION POLICY

In order to protect the safety and security of the Operators' Unit of the Organization, its students, employees, and the general public, the Heavy Equipment Operators program and the various courses in which students learn to operate commercial motor vehicles at Flathead Valley Community College; hereinafter known as the Operators' Unit of the Organization (OUO); has adopted the following policy regarding the use and possession of controlled (chemical) substances and alcohol by its commercial vehicle drivers, students, and employees who are covered by 49 CFR, §§ 40 and 382. The general term "operator(s)" will be used in place of "commercial vehicle driver(s), student(s), and employee(s)".

1. **INTOXICATING BEVERAGES**, without regard to alcohol content.

a. All operators are prohibited from being under the influence of any intoxicating beverage during working hours. No operator shall report for work while under the influence of any intoxicating beverage.

b. No operator shall consume any intoxicating beverage while on duty.

c. No operator shall use any intoxicating beverage on premises or in any motor vehicle owned or operated by the OUO. No operator shall bring to or store in OUO premises or any motor vehicle operated by the OUO an intoxicating beverage.

2. **CHEMICAL SUBSTANCES**

a. **Prescription drugs**. A prescription drug is any substance that the use or consumption of which has been prescribed by a licensed medical doctor. Prescription drugs shall be used only in the quantity, manner, frequency, for the duration and by the person for whom they as prescribed. No operator shall both use a prescription drug and report for or remain at work in circumstances where the use of the prescription drug could impair the ability of the operator to safely perform the functions of his or her job as if no drug were in use.

b. **Non-prescription substances.** No operator shall use any non-prescription substance in a manner which could impair the operator's safe performance of his/her duties.

c. **Illegal substances**. An illegal substance is any drug or other substance that the manufacture, distribution, transportation, possession, sale or consumption of which is illegal. All operators are prohibited from the manufacture, distribution, transportation, possession, sale or consumption of any illegal substance whether or not on duty or on OUO premises.

An operator who violates any of the above policies may be subject to discipline including termination.

CONTROLLED (CHEMICAL) SUBSTANCE & ALCOHOL TESTING PROGRAM-SUMMARY DESCRIPTION

To ensure that its Controlled (chemical) Substance and Alcohol Use & Possession Policy is adhered to; and to ensure compliance with 49 CFR, §§40 and 382; OUO has adopted the following testing program for the detection of controlled (chemical) substance and alcohol use by its operators subject to the regulations. This program has been developed in accordance with Federal Motor Carrier Safety Regulations; 49 CFR, §§40 and 382; and is administered in conformance with these regulations.

I. APPLICABILITY

Covered operators. This policy & testing program applies to operators and prospective operators who operate a commercial motor vehicle in commerce in any state and who are required to hold a commercial drivers license or commercial drivers learner's permit.

II. DEFINITIONS

Alcohol. Alcohol means the intoxicating agent in beverage alcohol, ethyl alcohol, or other low molecular weight alcohol, including methyl and isopropyl alcohol.

Controlled (Chemical) Substance. Controlled substance for purposes of this testing program means those substances so defined in 49 CFR, §40.85, including but not limited to, marijuana, cocaine, opiates including heroine (6MAM metabolite), phencyclidine (PCP), amphetamines (including methamphetamine), and MDMA (ecstasy).

Performing a Safety-Sensitive Function. An operator is considered to be performing a safety-sensitive function during any period in which he or she is actually performing, ready to perform, immediately available to perform or has just completed performance of any safety-sensitive function.

Positive Test. A positive alcohol test is defined as one in which the operator's blood alcohol concentration is 0.04 or greater. A positive controlled (chemical) substance test is defined as one in which the confirmatory test levels meet or exceed the levels stated in 49 CFR, part 40.

Prohibited Conduct. Prohibited conduct is individual, personal conduct; by an operator; which is prohibited under the OUO's Controlled (Chemical) Substance Use & Possession Policy and Testing Program; and 49 CFR, §382.201-§382.215.

Prohibited Substances. Prohibited substances include alcohol, alcoholic beverages, illegal substances (illegal drugs) and controlled substances (controlled drugs).

Refusal to Test. A refusal to test includes a failure to appear for any test within a reasonable time as determined by the OUO, after being directed to do so; failure to remain at the testing site until the testing process is complete; failure to provide a urine specimen for a drug test; failure to permit the observation or monitoring provision of a urine specimen in the case of a directly observed or monitored collection; failure to provide a sufficient urine or breath specimen when directed and it has been determined through a required medical evaluation that there was no adequate medical explanation for the failure; failure or declining to take a second test the OUO or the collector has directed the student to take; failure to undergo a medical examination or evaluation, as directed by the MRO as part of the verification process, or as directed by the OUO as part of the procedures set forth in 49 CFR, §40.193 or §40.265, as applicable; failure to attempt to provide a saliva or breath specimen as applicable; having an adulterated or

substituted controlled (chemical) substance test result, as verified by the MRO; failure to sign the certification of the Alcohol Testing Form; or failure to cooperate with any part of the testing process.

Safety-Sensitive Function. Safety-sensitive function means all the time from the time a driver begins class or is required to be in readiness to work until the time he or she is relieved from duty and all responsibility for performing work. Safety-sensitive functions shall include, but not be limited to:

1. All times at school, facility, or other property, or on any public property, waiting to be dispatched, unless the driver has been relieved from duty;
2. All time inspecting equipment to make sure that the parts, accessories, and emergency equipment are in good working order and ready for use or otherwise inspecting, servicing, or conditioning any commercial vehicle at any time;
3. All time spent at the driving controls of a commercial motor vehicle in operation;
4. All time, other than driving time, in or upon any commercial motor vehicle;
5. All time loading or unloading a vehicle, supervising, or assisting in the loading or unloading, attending a vehicle being loaded or unloaded, remaining in readiness to operate the vehicle, or in giving or receiving receipts for shipments loaded or unloaded; and
6. All time repairing, obtaining assistance, or remaining in attendance upon a disabled vehicle.

Substance Abuse Professional (SAP). A SAP is a licensed physician (Doctor of Medicine or Osteopathy), licensed or certified psychologist, licensed or certified social worker, licensed certified operator assistance professional, or drug and alcohol counselor certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NAADAC); or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC); or by the National Board for Certified Counselors, Inc. and Affiliates/Master Addictions Counselor (NBCC). The SAP must also meet all requirements set forth in 49 CFR, §40.281.

III. DRUG AND ALCOHOL TREATMENT RESOURCES

Operators who may be engaged in substance abuse or have developed substance addiction may contact Chris Moore at (406) 756-3602 for information regarding treatment programs and contacts. Additionally, abuse and addiction resource information is listed in the Drug and Alcohol-Use and Abuse Handbook provided to all operators by the OUO.

IV. PROHIBITED CONDUCT

The Following Conduct is Prohibited

1. Reporting for or remaining on duty requiring the performance of safety-sensitive functions while having an alcohol concentration of 0.04 or greater.
2. Reporting for or remaining on duty requiring the performance of safety-sensitive functions while the operator is under the influence of or impaired by alcohol.
3. Using alcohol while performing safety-sensitive functions.
4. Performing safety-sensitive functions within four hours after using alcohol.
5. Using alcohol within eight hours following an accident, unless the employee undergoes a post-accident alcohol test first.
6. Reporting for or remaining on duty requiring the performance of safety-sensitive functions when the operator uses any controlled substances, unless the use is pursuant to the instructions of a licensed medical doctor, who has advised the operator that the substance will not adversely affect the operator's ability to safely operate a commercial motor vehicle.
7. Reporting for or remaining on duty or performing a safety-sensitive function if the employee tests positive for controlled substances.
8. Refusing to submit to a drug or alcohol test as required under this policy and program.
9. Manufacturing, distributing, transporting, possessing, selling or consuming an illegal substance whether or not on OUO premises, in OUO vehicles or while on OUO business.

V. TESTING FOR PROHIBITED SUBSTANCES

Types and Frequency of Testing. Testing for controlled (chemical) substances will be conducted as a condition of enrollment or employment, on a random basis during duty, after certain work-related accidents, upon reasonable suspicion, before returning to duty after a confirmed positive test, and as a follow-up after a confirmed negative return-to-duty test. Testing for alcohol will be conducted on a random basis during duty hours, after certain work-related accidents, upon reasonable suspicion, before returning to duty after a confirmed positive test, and as a follow-up after a confirmed negative return-to-duty test. All testing will be conducted in accordance with 49 CFR, §40.

Student & Employee Testing. Every prospective student is required to test negative for the use of controlled (chemical) substances as a condition of duty. Employees returning to work for the OUO after an absence of 30 days or more will be required to undergo testing.

Random Testing. Operators are subject to unannounced, random testing which will be reasonably spaced over a twelve-month period. Random testing will include both controlled (chemical) substance and alcohol testing. Operators will be selected on a random basis using a scientifically valid method, such that each student has an equal chance of being tested each time selections are made.

Post-Accident Testing. An operator who is involved in an accident requiring post-accident testing must provide a urine sample and a breath sample in accordance with the collection procedures of 49 CFR, §40. The urine samples must be provided as soon as possible following the accident but in no event later than thirty-two hours thereafter. The breath sample must be provided as soon as possible following the accident but in no event later than eight hours thereafter.

An accident requiring post-accident testing is an accident involving a commercial motor vehicle that: 1) results in the death of a human being; or 2) results in an injury requiring immediate medical care away from the scene **and** the commercial driver received a traffic citation; or 3) results in disabling damage to a vehicle requiring it to be towed form the scene **and** the commercial driver received a traffic citation.

If a controlled (chemical) substance test required by this section is not administered within 32 hours following the accident, the OUO shall cease attempts to administer the test and shall prepare and maintain a record stating the reasons the test was not promptly administered.

If an alcohol test required by this section is not administered within 8 hours following the accident, the OUO shall cease attempts to administer the test and shall prepare and maintain a record stating the reasons the test ws not promptly administered.

Reasonable Suspicion Testing. An operator will be required to submit to testing whenever an instructor has reasonable suspicion to believe that the operator may have engaged in prohibited conduct within the meaning of this policy. The instructor's determination that reasonable suspicion exists must be based on specific observations concerning the appearance, behavior, speech, or body odors of the operator.

A urine sample must be provided as soon as possible following the reasonable suspicion determination, but in no event later than thirty-two hours thereafter. A breath sample must be provided as soon as possible following the reasonable suspicion determination, but in no event later than eight hours thereafter.

If a controlled (chemical) substance test required by this section is not administered within 32 hours following the reasonable suspicion determination, the OUO shall cease attempts to administer the test and shall prepare and maintain a record stating the reasons the test was not promptly administered.

If an alcohol test required by this section is not administered within 8 hours following the reasonable suspicion determination, , the OUO shall cease attempts to administer the test and shall prepare and maintain a record stating the reasons the test was not promptly administered.

Instructors will receive training in the physical, behavioral, speech, and performance indicators of probable alcohol misuse and use of controlled (chemical) substances, in accordance with 49 CFR, §382.603. Reasonable suspicion drug and alcohol testing may be conducted immediately before, during, or after the operator reports for duty.

Return-to-Duty Testing. If the OUO chooses to permit an operator to return to duty following a positive controlled (chemical) substance or alcohol test, the operator must submit to a return-to-duty test prior to performing a safety sensitive function. The test cannot occur until after a SAP has determined that the operator has successfully complied with prescribed evaluation, education and/or treatment.

An operator who engaged in prohibited conduct concerning controlled (chemical) substances shall undergo a return-to-duty controlled (chemical) substances test with a result indicating a verified negative for controlled (chemical) substance use. An operator who engaged in prohibited conduct concerning alcohol shall undergo a return-to-duty alcohol test with a result indicating an alcohol concentration of less than 0.02 before returning to duty.

Follow-up Testing. If the OUO chooses to permit an operator to return to duty following a positive controlled (chemical) substance or alcohol test and the operator has undergone a return-to-duty test with a confirmed negative test result; the operator will be subject to follow-up testing for up to 60 months.

VI. CONSEQUENCES OF ENGAGING IN PROHIBITED CONDUCT

The OUO will immediately remove an operator from safety sensitive functions if it receives a verified positive, adulterated, or substituted controlled (chemical) substance test result; an alcohol test result of 0.04 or greater; or if the operator refuses to be tested.

An operator whose alcohol BAC test result is between 0.02 and 0.399 will be immediately removed from safety sensitive functions until their next regularly scheduled work shift/class or 24 hours, whichever is longer.

Specific Consequences of Engaging in Prohibited Conduct

1. Initial Testing. A student whose test results are positive for a controlled (chemical) substance in an initial test will be dropped from the course.

2. Random Testing. The OUO may, at its discretion, grant a student personal leave of absence in which time s/he must obtain substance abuse evaluation, counseling and/or treatment. If the student fails to complete the required program or fails to return to duty before the expiration of the personal leave period, his/her student status in the course will be terminated.

A student whose test results for a second or subsequent random controlled (chemical) substance or alcohol test are positive will have his/her student status in the course terminated.

3. Post-Accident Testing. A student whose test results for a post-accident controlled (chemical) substance or alcohol test are positive will have his/her student status in the course terminated.

VII. CRIMINAL SANCTIONS

Individuals engaging in the manufacture, distribution, transportation, possession, sale or consumption of illegal substances may be subject to criminal charges under state and federal laws. These criminal charges may be brought by state and federal law enforcement agencies and are independent of this policy and program.

VIII. CONFIDENTIALITY

Information regarding results of testing under this policy will be released only in accordance with 49 CFR, §382.14; or when required to do so by a court or government agency of proper jurisdiction.
Information obtained through testing that is unrelated to the use of a controlled (chemical) substance or alcohol will be held in strict confidentiality by the MRO and will not be released to the company or program administrator.

IX. PROGRAM ADMINISTRATOR

This Drug & Alcohol Testing Program is administered by:

SafeTrac Solutions, Inc
PO Box 911
Great Falls, MT 59403-0911
(406) 727-9000

The administrator provides the company with drug specimen collection, drug testing, MRO services, alcohol testing random selection and reporting services.

X. QUESTIONS REGARDING THE PROGRAM

Questions regarding the Company's Drug and Alcohol Testing Program can be answered by contacting Chris Moore, at (406) 756-3602

This testing program is intended to comply with 49 CFR, §§40 and 382 and incorporates by reference the regulations. This summary is provided as a convenience and is not intended to modify, expand or restrict the scope of the regulations.

Flathead Valley Community College may change this program without notice.

Policy and Program Effective Date: 08/01/2013
Revision Number: Original

Receipt and Acknowledgment
Drug and Alcohol Use & Possession Policy and Testing Program

I have been given a copy of Flathead Valley Community College's Controlled (Chemical) Substance Use and Possession Policy and the Program Summary Description. Additionally, I have received educational materials regarding Alcohol & Substance Use & Abuse. I understand the Company's Controlled (Chemical) Substance Use and Possession Policy and the Program and agree to abide by its terms. I also understand the consequences of my failure to comply.

Furthermore, I understand that my compliance with this policy and program is a condition of employment and continuing employment with Flathead Valley Community College. I voluntarily give my consent to submit to Controlled (Chemical) Substance and Alcohol Testing as descried in this policy and program.

Date: ____/____/____

Print Name: _____

Signature: _____

Flathead Valley Community College

Student Health Clinic

Thank you for your visit today to the FVCC Student Health Clinic.

Please review, complete and sign the attached forms as follows:

1. **Face Sheet-verify/update the printed information. Please indicate if you have a preferred phone number.**

2. **New Patient Registration Form-additional information including Medicare and/or Montana Medicaid insurance, emergency contact, consent for treatment, and authorization to discuss medical care (optional).**

3. **Medical History Form-please complete both sides.**

4. **Notice of Privacy Practices-please read and sign page 3; indicate if you would like a copy of this form.**

5. **Student Bill of Rights & Responsibilities- indicate if you would like a copy of this form.**

Flathead Valley Community College

Student Health Clinic
New Patient Registration Form

Last Name **First Name** **Middle**

I have verified and updated, if necessary, my address information? **YES** **NO**
I am covered by either Medicare and/or Montana Medicaid? **YES** **NO**
If yes, please provide your insurance card(s) so that they can be scanned into your electronic health record.

Emergency Contact Information

Name of Emergency Contact **Relationship**

Mailing Address: **City** **State** **Zip** **Phone number**

CONSENT

Patient consents to the services that may be provided in connection with his/her outpatient treatment from FVCC Student Health Clinic which may include, but is not limited to, routine diagnostic procedures, nursing care, and other medical services provided to patient upon the instructions of patient's physician(s), and/or mid-level providers. Patient acknowledges that no guarantees have been made regarding the outcome of the care. If patient is unable to sign, consent for treatment is given by his/her duly authorized representative, or, in cases of emergency, shall be implied if such representative is not available.

AUTHORIZATION TO DISCUSS MEDICAL CARE

_____ give my authorization to the FVCC Student Health Clinic to discuss my medical care with the following person (s). I understand this authorization will stay in effect until I ask to have it removed in writing.

Individual (s) Name: Relationship to Patient:

_____

_____

Printed Name:_____

Date: _____

Patient Signature/Authorized Representative

The Montana Department of Public Health and Human Services (DPHHS) has requested that we seek your consent to share your/your child's immunization data with the DPHHS Immunization Information System (IIS). DPHHS may release IIS data to other public health agencies as well as to your/your child's healthcare providers to assist in your/your child's medical care and treatment. In addition, DPHHS may release IIS data to schools in order to comply with immunization requirements. Also, if you do not check the "I Opt In" box at this time, you can always choose to opt out at a later time and/or have your/your child's immunization record removed at any time by contacting your county's health department. You understand that any such revocation will be not effective as to uses and/or disclosures already made in reliance upon this authorization.

THIS IS NOT A CONSENT TO RECEIVE ANY IMMUNIZATION, IT IS ONLY A CONSENT TO REPORT YOUR/YOUR CHILD'S IMMUNIZATION DATA TO THE DPHHS IIS. Therefore, if you do not check the "I Opt In" box, we will collect and enter your/your child's immunization records into the DPHHS database.

☐ YES, I OPT OUT OF THE DPHHS IMMUNIZATION SYSTEM

Printed Name: _____ **Signature:** _____ **Date:**_____

Flathead Valley Community College

Student Health Clinic

Medical History Form

Welcome to the Flathead Valley Community College Student Health Clinic. In our attempt to provide efficient care for you at your appointment, we encourage you to fill out this form prior to your visit with the provider. Thank you.

Patient Name: _____ **Date of Birth:** _____

Ethnicity:_____ **Male/Female/Transgender (circle)**

Past Medical History

- Weight loss / gain
- Vision problems
- Hearing problems
- Headaches
- Heart problems
- Blood clot or stroke
- High Blood pressure
- High Cholesterol
- Asthma
- Lung problems
- Stomach/intestinal problem
- Colon problems
- Thyroid problems
- Diabetes
- Liver problems
- Kidney/urinary problems
- Muscle/bone/joint problem
- Skin problem
- Depression/mental health problem
- Eating disorder
- Hereditary disease
- Neurological problems/seizures
- Anemia
- Cancer
- Sexually transmitted diseases
- Other

Describe any of the checked problems:

_____

_____

Primary Care Provider/Regular Doctor: _____

Allergies

Food/Environmental/Drug allergies: **Reaction:**

_____

_____

_____

Medications

Name of Medications: **Strength/Dose:** **When do you take this medication each day?**

_____

_____

_____

Surgical History

Please list past surgeries: **Dates:** **Location:** **Reason:**

_____

_____

_____

Flathead Valley Community College

Student Health Clinic
Medical History Form

Patient Name: _____

Family Medical History

Please indicate relationship: M= Mother, F= Father, S= Sister, B= Brother, C= Child
MGM= Maternal (mother's side) grandmother, MGF = maternal grandfather,
PGM= Paternal (father's side) grandmother, PGF= Paternal grandfather

Diabetes _____
High Blood pressure____
Heart Disease _____
Lung Problems_____
Other Problems:

Cancer_____
Colon Problems_____
Blood clots_____
Stroke_____

Thyroid problems _____
Mental Health _____
Substance abuse_____

_____

_____

Social History

Alcohol/ Tobacco exposure: Do you smoke or vape? ____
If yes, how many packs/cartridges per day?___ Number of years that you have smoked/vaped?___
Do you use chewing tobacco? ___ How many cans per week? ___
Do you or have you ever used street drugs? _____
Number of alcoholic drinks per week/day: _____
Are you sexually active?____ Sexual Orientation (optional)_____
Exercise information: Do you exercise regularly? __What type and how often?_____

_____

Occupation: _____ Religion (optional): _____
Who do you live with? _____ Marital status: _____
Do you feel safe at home?_____

If Female

Date of last period: _____ Date of last Pap smear: _____
Birth Control Method: _____
Any abnormal Pap Smears and when? _____ If so, was the following one normal? _____
Date of last mammogram: _____ Any abnormal mammogram? _____ Age at Menopause:_____

Obstetric History:
Number of Pregnancies: ____ Number of Living children: ____ Number of Miscarriages: ____ Number of Abortions: ____

Flathead Valley Community College

Student Health Clinic

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

Protected Health Information (PHI) is demographic and individually identifiable health information about you that will or may identify you and relates to your past, present or future physical or mental health condition and related health care services. Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, other healthcare providers, and other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at Student Health Services.

Flathead Valley Community College

Student Health Clinic

Notice of Privacy Practices

Directory Information: Unless you request that such information not be released, we may disclose limited "directory information" about you while you are a patient at the Student Health Clinic. Specifically, we may disclose your presence and general health condition to people who ask for you by name.

Individuals Involved In Your Care: Unless you object, we may disclose to a family member, other relative, or a close personal friend, or any other person you identify, protected health information directly relevant to that person's involvement with your care. We will also disclose protected health information to an individual if we reasonably infer from the circumstances, based on the exercise of professional judgment that you do not object to the disclosure.

Limited Uses When You Are Not Present or are incapacitated: If you are not present or cannot agree or object to disclosure of information because of incapacity or an emergency circumstance, we will, in the exercise of professional judgment, disclose protected information in your best interests. We may use professional judgment and experience to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies or other similar protected health information on your behalf.

In the Event of a Disaster: We may disclose medical information about you to other health care providers and to an entity assisting in a disaster relief effort to coordinate care and so your family can be notified about your condition and location.

Business Associates: We may disclose medical information to business associates with whom we contract so they may provide services on behalf of Student Health Services. We require all business associates to implement safeguards to protect medical information.

Verbal Permission: With your verbal permission, we may use or disclose your information to family members that are directly involved with your treatment.

To Avert a Serious Threat to Health and Safety: We may use and disclose medical information about you when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person, unless that information is learned during counseling or therapy. Any disclosure would only be to someone able to help prevent the threat. Mental Health records are subject to stricter disclosure guidelines. You may request a copy of those privacy practices.

Special Situations: In these special situations, disclosure of your protected health information would be in accordance with state and federal laws: Cancer registries and other registries; military personnel; worker's compensation; public health risks; health oversight activities; judicial and administrative proceedings; law enforcement; organ and tissue donation; coroners; medical examiners and funeral directors.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Flathead Valley Community College

Student Health Clinic

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Student Health Clinic.

- **Right of Access to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. Your request for records must be made in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another health care provider will review your request and the denial. We will comply with the outcome of this review.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be in writing and you must submit a reason that supports your request. We may deny your request for an amendment if it is not in writing or it does not include a reason to support your request. We may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by Student Health Services: is not part of the information that you would be permitted to inspect and copy; or is accurate and complete. If you disagree with our denial, you may submit a statement of disagreement or ask that your request become part of your record. In response, we may prepare a rebuttal as part of your record.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI. Such requests must be in writing. We are not required to agree to your request. If we do agree to your restriction, we will comply with your request unless the information is needed to provide for your emergency treatment.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask the reason for your request. We will accommodate reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Questions or Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Director of Medical Services, Chuck Jensen at 777 Grandview Drive, Kalispell, MT 59901 (406-756-3808) or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

Name: _____

Signature: _____ Date: _____

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

_____

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ○ Yes ○ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ Yes ○ No ○ Not Sure

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY (continued)

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Instructions for Completing the Medical Examination Report Form (MCSA-5875)

I. Step-By-Step Instructions

Driver:

Section 1: Driver information

- **Personal Information**: Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, gender, driver's license number and issuing state.
  - **CLP/CDL Applicant/Holder**: Check "yes" if you are a commercial learner's permit (**CLP**) or commercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
  - **Driver ID Verified By**: The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
  - **Question: Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box "yes" or "no" and if you aren't sure check the "not sure" box.
- **Driver Health History**:
  - **Have you ever had surgery:** Please check "yes" if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
  - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check "yes" if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
  - **#1-32:** Please complete this section by checking the "yes" box to indicate that you have, or have ever had, the health condition listed or the "No" box if you have not. Check the "not sure" box if you are unsure.
  - **Other Health Conditions not described above**: If you have, or have had, any other health conditions not listed in the section above, check "Yes" and in the box provided and list those condition(s).
  - **Any yes answers to questions #1-32 above:** If you have answered "yes" to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered "yes" to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked "yes" to question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

Medical Examiner:

Section 2: Examination Report

- **Driver Health History Review:** Review answers provided by the driver in the driver health history section and discuss any "yes" and "not sure" responses. In addition, be sure to compare the medication list to the health history responses ensuring that the medication list matches the medical conditions noted. Explore with the driver any answers that seem unclear. Record any information that the driver omitted. As the Medical Examiner conducting the driver's physical examination you are required to complete the entire medical examination even if you detect a medical condition that you consider disqualifying, such as deafness. Medical Examiners are expected to determine the driver's physical qualification for operating a commercial vehicle safely. Thus, if you find a disqualifying condition for which a driver may receive a Federal Motor Carrier Safety Administration medical exemption, please record that on the driver's Medical Examiner's Certificate, Form MCSA-5876, as well as on the Medical Examination Report Form, MCSA-5875.
- **Testing:**
  - **Pulse rate and rhythm, height, and weight:** record these as indicated on the form.
  - **Blood Pressure:** record the blood pressure (systolic and diastolic) of the driver being examined. A second reading is optional and should be recorded if found to be necessary.
  - **Urinalysis:** record the numerical readings for the specific gravity, protein, blood and sugar.
  - **Vision:** The current vision standard is provided on the form. When other than the Snellen chart is used, give test results in Snellen-comparable values. When recording distance vision, use 20 feet as normal. Record the vision acuity results and indicate if the driver can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors; has monocular vision; has been referred to an ophthalmologist or optometrist; and if documentation has been received from an ophthalmologist or optometrist.
  - **Hearing:** The current hearing standard is provided on the form. Hearing can be tested using either a whisper test or audiometric test. Record the test results in the corresponding section for the test used.
- **Physical Examination:** Check the body systems for abnormalities and indicate normal or abnormal for each body system listed. Discuss any abnormal answers in detail in the space provided and indicate whether it would affect the driver's ability to safely operate a commercial motor vehicle.

In this next section, you will be completing either the Federal or State determination, not both.

- **Medical Examiner Determination (Federal):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49). Complete the medical examiner determination section completely. When determining a driver's physical qualification, please note that English language proficiency (49 CFR part 391.11: General qualifications of drivers) is not factored into that determination.
  - **Does not meet standards:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41.
  - **Meets standards in 49 CFR 391.41; qualifies for 2-year certification:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified and if selecting other, specify the time frame.

  Determination that driver meets standards: Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, driving within an exempt intracity zone, etc.).

- **Determination pending:** Select this option when more information is needed to make a qualification decision and specify a date, on or before the 45 day expiration date, for the driver to return to the medical exam office for follow-up. This will allow for a delay of the qualification decision for as many as 45 days. If the disposition of the pending examination is not updated via the National Registry on or before the 45 day expiration date, FMCSA will notify the examining medical examiner and the driver in writing that the examination is no longer valid and that the driver is required to be re-examined.

  MER amended: A Medical Examination Report Form (MER), MCSA-5875, may only be amended while in determination pending status for situations where new information (e.g., test results, etc.) has been received or there has been a change in the driver's medical status since the initial examination, but prior to a final qualification determination. Select this option when a Medical Examination Report Form, MCSA-5875, is being amended; provide the reason for the amendment, sign and date. In addition, initial and date any changes made on the Medical Examination Report Form, MCSA-5875. A Medical Examination Report Form, MCSA-5875, cannot be amended after an examination has been in determination pending status for more than 45 days or after a final qualification determination has been made. The driver is required to obtain a new physical examination and a new Medical Examination Report Form, MCSA-5875, should be completed.

- **Incomplete examination:** Select this when the physical examination is not completed for any reason (e.g., driver decides they do not want to continue with the examination and leaves) other than situations outlined under determination pending.

- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.

- **Medical Examiner's Certificate Expiration Date**: Enter the date the **driver**'s Medical Examiner's Certificate (MEC) expires.

Medical Examiner Determination (State): Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations). Complete the medical examiner determination section completely.

- **Does not meet standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41 with any applicable State variances.

- **Meets standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified and if selecting other, specify the time frame.

  Determination that driver meets standards: Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, etc.).

- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner's Certificate Expiration Date**: Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

Results Form, MCSA-5850, to the National Registry, and the most recent dated exam will take precedence.

III. **To obtain additional information regarding this form go to the Medical Program's page on the Federal Motor Carrier Safety Administration's website at http://www.fmcsa.dot.gov/regulations/medical.**