DOT PHYSICAL EXAMINATION
FINANCIAL RESPONSIBILITY, RELEASES AND CONSENTS *(ver. 8.0)*

ExpressHEALTH Clinic Corporation ('**EHC**', '**we**' or '**us**') healthcare providers are certified with the National Registry of Department of Transportation Medical Examiners. **We** perform DOT physical examinations (the 'Examination') pursuant to the standards of the United States Department of Transportation ('DOT'), and **we** report our examination assessment findings to the Federal Motor Carriers Safety Authority ('FMCSA').

Unless **we** are contracted with your employer, **we** expect payment in full from **you** at the time of service. Before **your** examination is commenced or any service is rendered, **you** should confirm with **our** staff whether **we** are contracted with **your** employer.

You Should Be Aware That:

Pursuant to the provisions of the 'Commercial Motor Safety Regulation and Operators' (CFR 49, Subtitle I, Chapter V, Subchapter II, § 521 (b)(2)(b)), a civil penalty will be charged against any driver who provides a false or intentionally incomplete medical history.

Your Full Name (Please Print):_____

To ExpressHEALTH Clinic Corporation ("EHC"):

I. Consent for Treatment. **I** understand that the **EHC** healthcare providers are Family Nurse Practitioners (FNP). **I** understand that it is **my** obligation to disclose all of **my** patient health related medical history, current medications and allergies to the **EHC** FNP. **I** have accurately completed the questions and information requested on the reverse side of this form along with any other data collection forms and requests presented to **me** by **EHC,** including but not limited to, any pre-registration information requests and information requests related to certain conditions (e.g., Cardiovascular, Diabetic, Neuro/Muscular/Psychological, Respiratory, etc.). **I** understand that some findings resulting from the Examination may be disqualifying conditions that will adversely affect **my** ability to operate commercial motor vehicles pursuant to the regulations of the DOT. If **I** have questions regarding any other health condition except for the reason for today's Examination visit with EHC, **I** will present them to **my** regular health care provider, and **I** understand that **I** will need to follow up with **my** regular health care provider regarding those questions. **I** hereby consent to the Examination and assessment to be performed by the **EHC** FNP.

II. Release of Medical Records and EHC Privacy Practices. **I** understand that **EHC** will report the results of **my** application, Examination and certification to the FMCSA, and **I** hereby consent to and authorize the release of such information to FMCSA. **I** hereby authorize the release of any and all medical information about **me** to (1) any employer who has agreed to accept financial responsibility for the Examination and assessment, and (2) to other health care providers who may participate in the Examination of **me**. **EHC** has made available to me a copy of its privacy practices that I have read (or have had explained to me); **I** understand and approve those practices.

Acknowledgment of Me as the Responsible Party. **I** am the Responsible Party and **I** will be bound by the terms of this document. Unless **EHC** is contracted with **my** employer, the Financial Responsibility for any payments that may be owed to **EHC** for the Examination services, or other services, that I receive is ultimately my responsibility.

By signing below, I confirm that I have read (or have had explained to me), understand and agree to the statements herein:

Signed By:_____ Date:_____