www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

Intrastate CDL Disability Waiver or Hazardous Materials Variance Application

MED 30 (02/25/2017)

Valid in Virginia ONLY for Transporting Intrastate Freight, Property or Passengers.

Purpose: Use this form to apply for a CDL (Commercial Driver's License) disability waiver or hazardous materials variance. **NEW** waivers or variances are granted only for disabilities (3) and (10) listed in Federal Motor Carrier Safety Regulations FMCSA 49 C.F.R. Section (b) 391.41. **RENEWAL** waivers or variances are granted for disabilities (1), (2), (3) and (10). To apply for a new waiver or variance for disabilities (1) and (2) use CSL Skill Performance Evaluation Certificate Application (MED 13).

Instructions: Review Disability Types below and if you have disability (3) complete this form and submit with a Customer Medical Report (MED 2) completed by your medical provider and Customer Vision Report (MED 4) completed by your eye care professional. If you have disability (8) complete this form and submit with a Customer Medical Report (MED 2) completed by your medical provider. If you have disability (10) complete this form and submit with a Customer Vision Report (MED 4) completed by your eye care professional. Send all completed forms to Medical Review Services at the above address. If you have questions about completing this form, call Medical Review Services (804) 367-6203.

APPLICATION TYPE

Check one
☐ New Application disabilities (3) & (10) only
☐ Renewal Application

Will your commercial motor vehicle (cmv) operation transport hazardous materials? ☐ YES ☐ NO
If YES - a Hazardous Materials Variance may be issued to authorize you to transport hazardous materials, general freight and property.
If NO - a Disability Waiver may be issued to authorize you to transport general freight, property or passengers.

I understand that if granted a waiver or variance, it would be valid only in Virginia for transporting intrastate freight, property or passengers and therefore I certify that my CMV operations will be: ☐ NA - Non-excepted Intrastate ☐ EA - Excepted Intrastate
This self certification is based upon the qualification requirements under Title 19 30-20-150 of the VA Administrative Code.

DISABILITY TYPES (Check type of disability for which you are applying for a waiver/variance)

☐ **(3)** Have a history or clinical diagnosis of diabetes mellitus currently requiring insulin for control.

☐ **(8)** Have an established medical history of seizure or a clinical diagnosis of epilepsy

☐ **(10)** Do not have distant visual acuity or horizontal vision - with or without corrective lenses - that meets FMCSA CDL requirements.

APPLICANT DRIVER INFORMATION

If you change either your residence address or mailing address to a non-Virginia address, your CDL driver's license or identification (ID) card may be canceled.

FULL LEGAL NAME (last)	(first)	(middle)	(suffix)

SOCIAL SECURITY NUMBER OR DRIVER LICENSE NUMBER	DAYTIME TELEPHONE NUMBER ( )	DATE OF BIRTH (mm/dd/yyyy)	
RESIDENCE ADDRESS ☐ CHECK HERE IF THIS IS A NEW ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS ☐ CHECK HERE IF THIS IS A NEW ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER INFORMATION

COMPANY NAME	CARRIER SCC/ID NUMBER OR U.S. DOT NUMBER	
AUTHORIZED REPRESENTATIVE NAME (print)	TELEPHONE NUMBER ( )	FAX NUMBER ( )

BUSINESS ADDRESS	CITY	STATE	ZIP CODE

EMPLOYMENT INFORMATION

DRIVER JOB DUTIES

EMPLOYMENT DATE (mm/dd/yyyy) _____ to _____

COMMODITY TO BE TRANSPORTED (check all that apply)
☐ General Freight ☐ Property ☐ Passengers ☐ Hazardous Materials (Complete 3 boxes below)

YEARS OF EXPERIENCE HAULING HAZARDOUS MATERIALS	TYPE OF FREIGHT	TYPE OF HAZARDOUS MATERIALS

APPLICANT DRIVER AND CARRIER/COMPANY CERTIFICATION

I/We certify that the applicant is otherwise qualified pursuant to the Federal Motor Carrier Safety Regulations with the exception of the physical disability(ies) described in this application and if I/we are applying for a Variance I/we certify that I/we understand that the law requires me/us to notify DMV upon any change in employment.

I/we further certify and affirm that all information presented in this form is true and correct, that any documents I/we have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I/we make this certification and affirmation under penalty of perjury and I/we understand that knowingly making a false statement or representation on this form is a criminal violation.

DRIVER NAME (print)	DRIVER SIGNATURE	DATE (mm/dd/yyyy)

CARRIER/COMPANY AUTHORIZED REPRESENTATIVE NAME (print)	CARRIER/COMPANY AUTHORIZED REPRESENTATIVE SIGNATURE	DATE (mm/dd/yyyy)

APPLICANT NAME	DMV CUSTOMER NUMBER (as it appears on license

DISABILITY (3) - (This section to be completed by endocrinologist)

Does the applicant have diabetes or any other metabolic condition(s) that might affect operation of a commercial motor vehicle? ☐ YES ☐ NO

If YES, also complete applicable sections of Customer Medical Report (MED 2) and answer the questions below.

Has the driver had recurrent (two or more) hypoglycemic reactions resulting in loss of consciousness or seizure in the last 5 years or one episode in the last 12 months? ☐ YES ☐ NO

Has the driver had a recurrent (two or more) hypoglycemic reactions requiring the assistance of another person within the past five years or one episode within the last 12 months? ☐ YES ☐ NO

Has the driver had recurrent (two or more) hypoglycemic reactions resulting in impaired cognitive function in the past 5 years or one episode in the last 12 months? ☐ YES ☐ NO

Has the driver demonstrated willingness to monitor and manage his/her diabetes? ☐ YES ☐ NO

Is the driver likely to suffer any diminution of driving ability due to his/her diabetic condition? ☐ YES ☐ NO

Drivers seeking an insulin waiver must also submit a MED 4 and the driver agreement.

DISABILITY (8) - (This section is to be completed by neurologist)

Does this applicant have a documented history of seizure or a clinical diagnosis of epilepsy? ☐ YES ☐ NO

If YES, also complete Customer Medical Report (MED 2) and answer the questions below.

If the driver has a diagnosis of epilepsy, has he/she been seizure free for 8 years? ☐ YES ☐ NO

If the driver experienced a single unprovoked seizure has he/she been seizure free for 4 years? ☐ YES ☐ NO

If the driver is taking anti convulsants medications, have they been stable, or unchanged for 2 years? ☐ YES ☐ NO

If the driver experienced a single provoked seizure, address the cause on the MED 2.

DISABILITY (10) - (This section to be completed by ophthalmologist/optometrist)

Does the applicant have any visual defects, condition or field loss that would affect the safe operation of a commercial motor vehicle? ☐ YES ☐ NO

If YES, also complete a Customer Vision Report (MED 4) and answer the question below.

Is the driver able to distinguish between, red, green and amber colors? ☐ YES ☐ NO

Federal Motor Carrier Safety Regulations FMCSA 49 C.F.R. Section (b)(10) 391.41 requires distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green, and amber.

APPLICANT NAME	DMV CUSTOMER NUMBER (as it appears on license

MEDICAL PROVIDER CERTIFICATION

Based on my examination, this applicant is capable of safely operating a commercial motor vehicle - which includes operating tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

CHECK BOX THAT APPLIES: ☐ PHYSICIAN ☐ PHYSICIAN ASSISTANT ☐ NURSE PRACTITIONER ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST

MEDICAL PROVIDER NAME (print)	MEDICAL LICENSE NUMBER	STATE ISSUING MEDICAL LICENSE	EXPIRATION DATE (mm/dd/yyyy)

BUSINESS ADDRESS				
CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )	FAX NUMBER ( )

MEDICAL PROVIDER SIGNATURE	DATE (mm/dd/yyyy)

VIRGINIA DMV DIABETES WAIVER DRIVER AGREEMENT

Read and initial applicable statements. Sign and date at the bottom of section.

INITIAL	I agree to carry a source of rapidly absorbable glucose at all times while driving.
INITIAL	I agree to self-monitor blood glucose levels prior to driving and every 2 - 4 hours while driving, using a portable monitoring device equipped with a computerized memory.
INITIAL	I agree to submit blood glucose logs to the endocrinologist and to DMV at least annually.
For non-excepted intrastate drivers:	
INITIAL	I agree to supply the endocrinologist report and blood sugar logs to the medical examiner annually or when otherwise directed to by an authorized agent of the FMCSA.

DRIVER NAME (print)	DRIVER SIGNATURE	DATE (mm/dd/yyyy)