INSTRUCTIONS FOR FILLING OUT FORM OF 345
PHYSICAL FITNESS INQUIRY FOR MOTOR VEHICLE OPERATORS

STOP!!

If you would like to be a DAV driver, you MUST fill out BOTH the Volunteer Application Forms AND the Physical Fitness Inquiry for Motor Vehicle Operators Forms below

Thank you for volunteering to be a DAV driver!

Travel benefit cuts left many Veterans with no way to get to Department of Veterans Affairs (VA) medical facilities for needed treatment. They're men and women who answered our country's call in times of war. Many lost limbs, sight, hearing, or good health. They may live a great distance from a VA hospital, and many Veterans have found that the cost of transportation to a VA hospital is just too high. They're left with two choices. They could go without the treatment they need, or skimp on food or other necessities to pay for transportation.

Veterans disabled in our nation's service should never face such dire options. So the Disabled American Veterans (DAV) volunteers respond, driving vets to and from VA hospitals and clinics. The DAV Transportation Network is the only way many veterans are able to get to a medical facility for needed treatment. The DAV TN is comprised of volunteers just like yourself who want to 'give back' to the Veteran in a special way.

- ***Please have your Primary Care Physician fill out Form OF345completely, and sign where applicable.***

- ***Please provide proof of valid, current driver's license and personal automobile insurance***

Please call the Voluntary Service Office at 401-273-7100, ext 3002 with questions.

OF 345 (VISN 8 amended)
(11/85)
Office of Personnel Management

PHYSICAL FITNESS INQUIRY FOR MOTOR VEHICLE OPERATORS

1. Name (Last, First, Middle) SS: _____ - ____ - _____	2. Date of Birth (Month/Day/Year) / /	3.Title of Position Volunteer Driver County:

4. Street: _____
City: _____ State: _____
Zip: _____
Home Telephone: _____ - _____
(area code)

VA Medical Center
Voluntary Service (135)
830 Chalkstone Avenue
Providence, RI 02908

6. Have you ever had or have you now (Place a check at left of each item)

Yes	No		Yes	No	
☐	☐	Poor vision in one or both eyes	☐	☐	Arthritis, rheumatism, swollen or painful joints
☐	☐	Eye Disease	☐	☐	Loss of hand, arm, foot, or leg
☐	☐	Poor hearing in one or both ears	☐	☐	Deformity of hand, arm, foot, or leg
☐	☐	Diabetes	☐	☐	Nervous or mental trouble of any kind
☐	☐	Palpitation, chest pain, or shortness of breath	☐	☐	Blackouts or epilepsy
☐	☐	Dizziness or fainting spells	☐	☐	Sugar or albumin in urine
☐	☐	Frequent or severe headaches	☐	☐	Excessive Drinking habit (Alcohol)
☐	☐	High or low blood pressure	☐	☐	Other serious defects or diseases (i.e. Head/Neck range of motion disorders; Syncope; Ischemia; Rhythm or rate disturbances of the heart; Pacemaker; serious heart valve disease; Heart Block; Ejection Fraction less than 40%; COPD; Narcolepsy; Neuromuscular Impairments; Stroke; Meniere's Disease)
☐	☐	Drug or narcotic habit			

7. If you answer is "Yes" to one or more of the above questions, explain fully in this space, indicating date of original condition and current status (if additional space is needed, please use the back of this form):

8. (A) Do you wear glasses (or contact lenses) while driving? ☐ Yes ☐ No
(B) Do you wear a hearing aid? ☐ Yes ☐ No

PRIVACY ACT STATEMENT

Solicitation of this information is authorized by 40 U.S.C. 491 and 5 CFR Part 930 Subpart A, which require OPM to regulate Federal applicants use of Government-owned or -leased motor vehicles. It is used to ascertain the physical fitness of Federal applicants, whose jobs require authorization to drive Government-owned or -leased vehicles. It is also used in the renewal of authorizations. Based on the information provided, applicants may be referred for a medical examination before being granted an initial authorization or a renewal. The disclosure of this information is mandatory when an applicant's job requires driving a Federal motor vehicle and is voluntary otherwise. However, failure to complete when requested may result in you not being permitted to operate a Government vehicle.

Certification: I certify that my answers to the above are full and true and I understand that a willfully false statement or dishonest answer may be grounds for cancellation of my eligibility or my dismissal from the service and is punishable by law.	9.Signature ☒	10. Date Signed (Month, Day, Year)

REVIEW AND CERTIFICATION BY DESIGNATED OFFICIAL

I certify that I have reviewed this physical fitness inquiry form and other available information regarding the physical condition of the applicant, and I have made the following determination:

☐ 1. There is no information on this form or otherwise available to indicate that the applicant should be referred for physical examination (i.e. volunteer driver applicant suitable after considering criteria in Attachment A to IL 13-2003-001).

☐ 2. On the basis of items checked on this form or other information, this applicant must be referred for physical examination before authorized to operate a Government-owned or leased motor vehicle or current authorization is renewed. Reason(s) for non-acceptance as a volunteer driver and referral to volunteer's treating Provider (based on the criteria in Attachment A to IL 13-2003-001):

HEALTH REVIEW FOR VOLUNTEER DRIVER IS:

☐ APPROVED OR ☐ DISAPPROVED

Signature of Designated Official (Occupational Health Provider) NAME OF PHYSICIAN: _____ SIGNATURE: _____	Date Signed (Month, Day, Year)

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
830 Chalkstone Avenue
Providence RI 02908-4799

Dear Doctor

Your patient, _____, is/has applied to be a volunteer driver for the Providence VAMC. He operates cars/vans and transports passengers. We are asking the volunteers to obtain a list of diagnoses and the medications they are on from their Primary Care Doctors. We ask that you review the attached exclusionary criteria for a volunteer driver and sign below. Thank-you in advance for your assistance

Jeanne Kinsella, NP
Employee Health
VAMC

Diagnoses

_____

_____

Medication Name	Dose	Frequency

I have reviewed the exclusionary criteria for volunteer drivers and to my knowledge this patient is able to operate a car/van safely

_____
Printed Name

_____
Signature DATE

CLARIFICATION TO OFFICE OF PERSONNEL MANAGEMENT (OPM) OFFICIAL FORM (OF) 345

1. The following is a clarification the Office of Personnel Management (OPM) Official Form 345, Physical Fitness Inquiry for Motor Vehicle Operators, currently in wide use across the Veterans Health Administration (VHA). Follow-up physical examination, testing, or other appropriate action, including denial of driving duties, may be indicated.

NOTE: A diagnosis of any of the following medical conditions may not necessarily result in the declination of a volunteer as a driver as the qualification is made on an individual basis after a review of all appropriate medical documentation from the volunteer candidate's primary care or other provider.

2. Criteria that clinicians may consider when deciding if a volunteer is medically qualified as a driver include:

a. **Vision.** Vision needs to be 20/40 or better in each eye with or without correction.

b. **Hearing Loss.** Hearing loss needs to be no greater than an average of 40dB at 500, 1000, and 2000 HZ in the better ear with or without hearing aids.

c. **Diabetes.** A clinical diagnosis of diabetes mellitus should generally not require insulin for control.

d. **Substance Abuse.** The applicant with a history of substance abuse needs to provide documentation of being followed in a treatment program and documentation of abstinence for 1 year is provided.

e. **Epilepsy.** There is no history or clinical diagnosis of epilepsy.

f. **Range of Motion of Head and Neck.** There needs to be more than 45 degrees of rotation to both right and left.

g. **Hypertension.** Hypertension needs to be under control with blood pressure no greater than 180 over 105.

h. **Syncope.** Syncope, except when postural hypotension is found to be the cause, is absent.

i. **Ischemia.** There is no clinical diagnosis of Ischemia, as evidenced by stress test.

j. **Ventricular Arrhythmias.** There is no current clinical diagnosis of ventricular arrhythmias, excluding random Premature Ventricular Contractions.

k. **Pacemaker.** Every 6 months the applicant needs to provide documentation that it is functioning adequately.

l. **Heart Block.** There is no current clinical diagnosis of a complete heart block, or new bundle branch block.

m. **Critical Aortic Stenosis.** The applicant needs to provide documentation of an evaluation by a cardiologist.

n. **Ejection Fraction.** Ejection farction needs to be greater than 40 percent.

o. **Chronic Obstructive Pulmonary Disorder (COPD).** A clinical diagnosis of moderate to severe COPD with a FEV 1 of less than 60 percent is considered a disqualifying condition.

p. **Narcolepsy and/or Sleep Apnea.** The applicant needs to provide documentation of adequate treatment as confirmed by sleep study needs.

q. **Neuromuscular Impairments.** The applicant needs to be able to coordinate all four extremities.

r. **Stroke.** A clinical diagnosis of a cerebral vascular accident is considered a disqualifying condition.

s. **Meniere's Disease.** Unstable or active Meniere's Disease is considered a disqualifying condition.

t. **Intra-Atrial Conduction Delay (IACD).** A clinical diagnosis of IACD is considered a disqualifying condition.

NOTE: Many facilities report including in the process a Driver test under observation to *confirm the applicant's physical ability to control the vehicle.*

DRIVERS
Volunteers and Employees
Exclusionary Criteria

1. Less than 20/40 vision uncorrected in each eye. NOTE: Both eyes are a requirement to drive.
2. Insulin Dependent Diabetes
3. History of substance abuse unless followed in a treatment program and abstinence is documented for one year
4. History of syncope, except postural hypotension is found to be the cause
5. Driver test under observation on grounds to confirm the physical ability to control the vehicle
6. History of ventricular arrhythmia excluding random PVCs
7. Complete heart block or documented new bundle branch block
8. Critical aortic stenosis (to be evaluated by a cardiologist)
9. Ejection fraction of less than 40%
10. Hearing loss of more than average of 40dB in the best ear at 500, 1000 and 2000 HZ
11. Limited range of motion of head and neck precluding ability to see from side to side (a minimun of 45 degrees)
12. Neuromuscular impairments (ability to coordinate all four extremities)
13. Hypertension of greater than 180/105
14. History of stroke
15. Severe COPD (FEV1 of less than 60%)
16. Narcolepsy/sleep apnea (unless adequately treated as confirmed by sleep study)
17. Unstable or active Meniere's Disease
18. IACD
19. Pacemaker (unless documentation is provided q six months that pacemaker is functioning adequately)
20. Ishchemia (on medication) during cardiac stress test