

# EMPLOYEE HEALTH PRESCREENING FOR VOLUNTEER DRIVERS

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

**AUTOMATIC DISQUALIFIERS:** Volunteers must have NO known HISTORY or DIAGNOSIS of the following medical conditions: **EPILEPSY** (seizure disorder), **SYNCOPE** (blacking or passing out within the last 1 year), **HEART ATTACK** (within the last 1 year), **VENTRICULAR ARRHYTHMIAS, IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD), COMPLETE HEART BLOCK, USE OF CONTAINERIZED OXYGEN, STROKE** and **ACTIVE TRANSIENT ISCHEMIC ATTACKS (TIA'S), MENIERS DISEASE** (active inner ear disease causing a balance disorder), and **INTRA-ATRIAL CONDUCTION DELAY (IACD)**. These are considered absolute disqualifiers for volunteer drivers.



IF YOU HAVE ANY OF THE CONDITIONS ABOVE, please stop here and contact Voluntary Service at 843-789-7230 or [vhachavavs@va.gov](mailto:vhachavavs@va.gov) for placement in a volunteer assignment that does not include driving. If not, please continue.

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**Conditions below are not automatic disqualifiers, but note that DOCUMENTATION that these conditions are controlled will be required. Please read carefully.**

## **You must bring documentation requested below to your physical exam appointment .**

**1. DIABETES.** VOLUNTEERS WITH A CLINICAL DIAGNOSIS OF DIABETES MELLITUS **MUST HAVE A HEMOGLOBIN A1c OF LESS THAN 8** AND HAVE **NO SYMPTOMS OF DIZZINESS OR FATIGUE** THAT MIGHT SUGGEST THE PRESENCE OF HYPO- OR HYPERGLYCEMIC EPISODES DURING THE PAST SIX MONTHS.

Do you have diabetes?  Yes  No

If yes, volunteer must bring copy of last hemoglobin A1c result to your appointment.

Have you had a low blood sugar episode or experience dizziness or fatigue?  Yes  No

**2. SUBSTANCE ABUSE.** VOLUNTEERS WITH A HISTORY OF SUBSTANCE ABUSE MUST PROVIDE DOCUMENTATION OF BEING FOLLOWED IN A TREATMENT PROGRAM AND PROVIDE DOCUMENTATION OF ABSTINENCE FOR 1 YEAR.

Do you have a history of drug and/or alcohol abuse?  Yes  No

If yes, has this been in the last 3 yrs?  Yes  No

If yes, volunteer must bring documentation that they are in a treatment program or a letter from their provider documenting that they have been abstinent for at least 1 year to your appointment.

**3. HYPERTENSION.** BLOOD PRESSURE **NO GREATER THAN 160 OVER 95** WITHOUT EVIDENCE OF ACUTE HYPERTENSIVE EFFECTS OR HYPERTENSION-RELATED SYMPTOMS.

Do you have high blood pressure?  Yes  No

If yes, is it treated with medications?  Yes  No

**4. PACEMAKER.** EVERY 6 MONTHS THE VOLUNTEER NEEDS TO PROVIDE DOCUMENTATION THAT HIS OR HER PACEMAKER IS FUNCTIONING ADEQUATELY.

Do you have a pacemaker?  Yes  No

If yes, volunteer needs to bring documentation from their provider documenting that your pacemaker is functioning adequately to your appointment.

**5. AORTIC STENOSIS.** FOR CLEARANCE, VOLUNTEERS WITH THIS CONDITION MUST PROVIDE DOCUMENTATION OF AN EVALUATION BY A CARDIOLOGIST. THOSE WITH SYMPTOMS OF DECLINING LEFT VENTRICULAR FUNCTION, OR WHO ARE IN NEED OF AORTIC VALVE REPLACEMENT (AVR) CAN NOT BE MEDICALLY CLEARED.

Do you have aortic stenosis? (narrowing of the aortic valve)?  Yes  No

**6. CHRONIC OBSTRUCTIVE PULMONARY DISORDER (COPD).** A CLINICAL DIAGNOSIS OF MODERATE TO SEVERE COPD WITH A FEV 1 OF LESS THAN 40 PERCENT IS CONSIDERED A DISQUALIFYING CONDITION.

Do you have COPD including emphysema and/or chronic asthmatic bronchitis? Symptoms include shortness of breath, wheezing, chest tightness, and/or chronic cough  Yes  No

If yes, volunteer needs to bring the documentation described above (Spirometry that shows an FEV1 of greater than 40%) from their provider to employee health appointment.

**7. NARCOLEPSY AND/OR SLEEP APNEA.** IN THE PRESENCE OF NARCOLEPSY AND SLEEP APNEA, THE VOLUNTEER MUST PROVIDE DOCUMENTATION OF ADEQUATE TREATMENT AS CONFIRMED BY A SLEEP STUDY.

Do you have a clinical diagnosis of narcolepsy and/or sleep apnea?  Yes  No

Do you use a CPAP?  Yes  No

If yes, volunteer needs to bring letter from provider indicating this applicant is under the provider's care for sleep apnea, and is adequately treated to transport Veterans by motor vehicle. Provider's statement must be on letterhead with provider's name, address, phone number.

**8. PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING (just the name of the medicine – doses are NOT required):**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

**9. PLEASE LIST ANY MEDICAL CONDITIONS OR MEDICAL HISTORY OR SURGERIES YOU HAVE THAT WAS NOT MENTIONED ABOVE:**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.

**10. PLEASE LIST ANY ALLERGIES TO MEDICATIONS YOU MAY HAVE:**

1.	5.
2.	6.
3.	7.
4.	8.

**“I HEREBY CERTIFY THE ABOVE INFORMATION IS COMPLETE AND TRUTHFUL. I UNDERTAND THAT THE RALPH. H. JOHNSON VAMC WILL PROVIDE AN ELECTROCARDIOGRAM AND A1C (DIABETES TEST) TO ALL DRIVER CANDIDATES FREE OF CHARGE. I UNDERSTAND THAT ANY FURTHER TESTING OR EXAMINATIONS REQUIRED TO MEET THE ABOVE REQUIREMENTS WILL BE AT THE EXPENSE OF THE VOLUNTEER. I UNDERSTAND THAT THE DETERMINATION OF SUITABILITY TO DRIVE A VOLUNTEER VAN WILL BE AT THE CLINICAL JUDGMENT OF THE MEDICAL EXAMINER AND IS FINAL.”**

**Signature:\_\_\_\_\_ Date:\_\_\_\_\_**

**Drivers aged <55 must have repeat medical examination every 4 years  
Drivers aged 55 - 65 must have repeat medical examination every 2 years  
Drivers aged >65 must have repeat medical examination every year**

**>> All drivers must have ANNUAL TB testing regardless of how often you are required to have your next medical examination! <<**

***“Thank you for your time, help, and commitment to volunteering at the Ralph H Johnson VA Medical Center. We understand that we ask a lot of you to undergo medical examination and testing. It is not our intention to make the process for you to become a volunteer driver difficult. Please understand, that we treat every driver applicant as though you would be personally transporting one of our own family members: our veterans deserve no less. You are a vital part of our team and we honor your contribution to our veterans and appreciate your willingness to everything you do!”***

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