Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined **Last Name:** _____ **First Name:** _____ in accordance with *(please check only one)* :

☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)* **OR**

☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)*

☐ Wearing corrective lenses ☐ Accompanied by a _____ waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*

☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Grandfathered from State requirements *(State)*

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date

Medical Examiner's Signature _____

Medical Examiner's Telephone Number _____

Date Certificate Signed _____

Medical Examiner's Name (please print or type) _____

☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse

☐ DO ☐ Chiropractor ☐ Other Practitioner *(specify)* _____

Medical Examiner's State License, Certificate, or Registration Number _____

Issuing State _____

National Registry Number _____

Driver's Signature _____

Driver's License Number _____

Issuing State/Province _____

Driver's Address

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

CLP/CDL Applicant/Holder

☐ Yes ☐ No

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