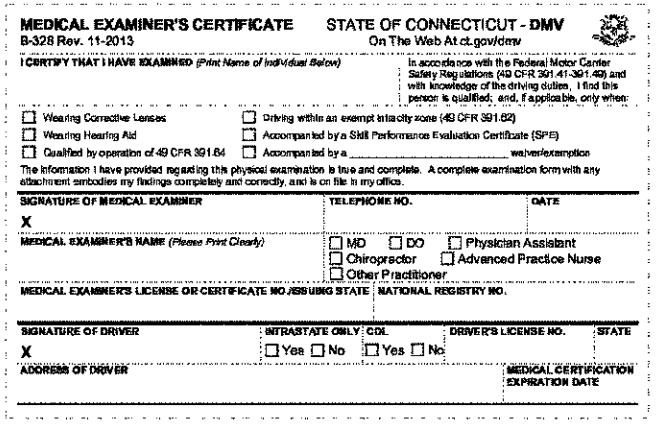
Please keep this card for your record do not mail to the DMV.



MEDICAL EXAMINER'S CERTIFICATE STATE OF CONNECTICUT - **DMV**
B-328 Rev. 11-2013 On The Web At ct.gov/dmv

I CERTIFY THAT I HAVE EXAMINED *(Print Name of Individual Below)*

In accordance with 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:

- ☐ Wearing Corrective Lenses
- ☐ Wearing Hearing Aid
- ☐ Qualified by operation of 49 CFR 391.64
- ☐ Driving within an exempt intracity zone (49 CFR 391.62)
- ☐ Accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ Accompanied by a _____ waiver/exemption

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER	TELEPHONE NO.	DATE
X		

MEDICAL EXAMINER'S NAME *(Please Print Clearly)*

☐ MD ☐ DO ☐ Physician Assistant
☐ Chiropractor ☐ Advanced Practice Nurse
☐ Other Practitioner

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE | **NATIONAL REGISTRY NO.**

SIGNATURE OF DRIVER	INTRASTATE ONLY	CDL	DRIVER'S LICENSE NO.	STATE
X	☐ Yes ☐ No	☐ Yes ☐ No		

ADDRESS OF DRIVER | **MEDICAL CERTIFICATION EXPIRATION DATE**

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

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
☐ Wearing hearing aid
☐ Accompanied by a _____ waiver/exemption
☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
☐ 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 examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date

Signature of Medical Examiner

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner 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

Signature of Driver

Driver's License Number

Issuing State/Province

Address of Driver

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

CLP/CDL Applicant/Holder

◯ Yes ◯ No

Form MCSA-5875 (Revised: 04/01/2013) OMB No. 2126-0006 Expiration Date:

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

PRIVACY ACT STATEMENT *This statement is provided pursuant to the Privacy Act of 1974,* 5 USC § 552a
AUTHORITY: Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).
PURPOSE: To record results of a driver's physical examination to determine qualification to operate a commercial motor vehicle (CMV) in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49.
Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].
ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.
In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses" (available at http://www.dot.gov/privacy/privacyactnotices).
ACKNOWLEDGMENT: *I understand the provisions of the Privacy Act of 1974 as related to me through the abovementioned statement.*

MEDICAL RECORD #
_____
(or sticker)

CMV Driver Signature: _____ Date: _____

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: _____ Age: ___ Gender: ○ M ○ F

Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____

Driver License Number: _____ State of Issue: _____ Intrastate Only? ○ Yes ○ No CDL*? ○ Yes ○ No Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No

DRIVER HEALTH HISTORY

Do you have or have your ever had:	Yes	No		Yes	No
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	16. Dizziness, headaches, numbness, tingling, or memory loss	○	○
2. Seizures, epilepsy	○	○	17. Unexplained weight loss	○	○
3. Eye problems *(except glasses or contacts)*	○	○	18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○
4. Ear and/or hearing problems	○	○	19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	20. Neck or back problems	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	21. Bone, muscle, joint, or nerve problems	○	○
7. High blood pressure	○	○	22. Blood clots or bleeding problems	○	○
8. High cholesterol	○	○	23. Cancer	○	○
9. Chronic cough, shortness of breath, or other breathing problems	○	○	24. Chronic infection or other chronic diseases	○	○
10. Lung disease *(e.g., asthma)*	○	○	25. Problems staying awake, loud snoring	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	26. Sleep apnea	○	○
12. Stomach, liver, or digestive problems	○	○	27. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○
13. Diabetes or blood sugar problems	○	○	28. Have you ever spent a night in the hospital?	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	29. Have you ever been treated for mental health problems?	○	○
15. Fainting or passing out	○	○	30. Have you ever had a broken bone?	○	○
31. Have you ever had surgery? If "yes," please list and explain below.	○	○	32. Other health condition(s) not described above	○	○
33. Are you currently taking medications *(prescription, over-the-counter, herbal, diet supplements)*? If "yes," please describe below.	○	○	34. Did you answer "yes" to any of questions 1-30? If so, please comment further on those health conditions below.	○	○

(Attach additional sheets if necessary)

*CDL Yes/No: Commercial driver's license (CDL) means a license issued to an individual by a State or other jurisdiction of domicile, in accordance with the standards contained in 49 CFR part 383, which authorizes the individual to operate a class of a commercial motor vehicle. CDL includes a commercial learner's permit (CLP). Check yes if the person is a CDL holder or is applying to become a CDL holder.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

Last Name: _____ First Name: _____ Middle Initial: ____ Date: _____

DRIVER LIFESTYLE QUESTIONS

	Yes	No		Yes	No
35. Have you ever used or do you now use tobacco?	○	○	37. Have you used an illegal substance within the past 2 years?	○	○
36. Do you currently drink alcohol?	○	○	38. Have you ever failed a drug test or been dependent on an illegal substance?	○	○

DRIVER SIGNATURE

A driver is expected to provide the medical examiner with an accurate and complete medical history, as indicated in this Form that is part of 49 CFR 391.43. A driver who provides fraudulent or intentionally false information is in violation of 49 CFR 390.35, and would be subject to the penalties under 49 CFR 390.37.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

Review and discuss pertinent driver answers and any available medical records

Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

TESTING

Last Name: _____ First Name: _____ Middle Initial: ____ Height: __ *feet* ___ *inches* Weight: ____ *pounds*

Neck circumference *(optional)**: ___ *inches* BMI *(optional)**: ___ Pulse rate: _____ Pulse rhythm regular: ○ Yes ○ No

**(Please note that a neck circumference greater than 17" for men/16" for women OR a body mass index greater than 33 are both risk factors for sleep apnea.)*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading (optional)		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other testing if indicated *(e.g., A1C, EKG; see FMCSA guidance)*

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/____	20/____	Right Eye: ____ degrees
Left Eye:	20/____	20/____	Left Eye: ____ degrees
Both Eyes:	20/____	20/____	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

*Standard: Must first perceive whispered voice at greater than 5 feet (with or without hearing aid **OR** average hearing loss in better ear at less than 40 dB.*

Check if hearing aid used for test: ○ Right Ear ○ Left Ear ○ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	_____	_____

OR

Audiometric Test Results

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
_____	_____	_____	_____	_____	_____

Average (right): _____ Average (left): _____

Last Name: _____ First Name: _____ Middle Initial: ____ Date: _____

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check if the body system is normal, or if there are any abnormalities. Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment. If organic disease is present, note if it has been compensated for.

Body System	Normal	Abnormal	**Body System**	Normal	Abnormal
1. General	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Inguinal hernia *(male only)*	○	○
3. Eyes	○	○	10. Back	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Spine	○	○
6. Heart	○	○	13. Neuro/reflexes	○	○
7. Lungs/chest	○	○	14. Gait	○	○

Impressions:

(Attach additional sheets if necessary)

MEDICAL EXAMINER DETERMINATION

○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

○ Does not meet standards *(explain why)*: _____

○ Meets standards, but periodic monitoring required *(due to)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid

☐ Accompanied by a waiver/exemption *(Driver must present exemption certificate at time of certification)*

☐ Accompanied by a Skill Performance Evaluation (SPE) certificate

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62)*

☐ Qualified by operation of 49 CFR 391.64

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner Signature: _____ Medical Examiner Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____

Medical Examiner's License or Certificate Number: _____ ☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor

State issuing License or Certificate: _____ ☐ Advanced Practice Nurse ☐ Other Practitioner

National Registry Number: _____ Medical Certificate Expiration Date: _____

Determination pending *(specify reason)*: _____

Return to medical exam office for follow-up on *(must be 45 days or less)*: _____

Comment on reasons for amendment: _____

(if amended) Medical Examiner Signature: _____ Date: _____