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

OMB No. 2126-0006 Expiration Date: Form MCSA-5876 (Revised: 04/24/2015)

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Medical Examiner's Certificate (for Commercial Driver Medical Certification)

certify that have examined Last Name:	First Name:	in accordance with (please check only one):	rone):
O 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 O 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):	with knowledge of the driving duany applicable State variances (w	uties, I find this person is qualified, and, vhich will only be valid for intrastate op	if applicable, only when <i>(check all that apply)</i> OR erations), and, with knowledge of the driving duties,
 ■ Wearing corrective lenses ■ Accompanied by a waiver/exemption ■ Wearing hearing aid ■ Accompanied by a Skill Performance Evaluation (SPE) Certificate 	waiver/exemption	☐ Driving within an exempt intracity zone (4 <u>9 CFR 391.62)</u> (Federal) ☐ Qualified by operation of <u>49 CFR 391.64</u> (Federal) ☐ Grandfathered from State requirements (State)	zone (<u>49 CFR 391.62)</u> (Federal) <u>91.64</u> (Federal) nents (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.	and complete. ompletely and correctly, and is or	nfile in my office.	Medical Examiner's Certificate Expiration Date
Signature of Medical Examiner	Medica	Medical Examiner's Telephone Number	Date Certificate Signed
Medical Examiner Name (please print or type)	OG O	O Physician Assistant O Chiropractor	O Advanced Practice Nurse
Medical Examiner's State License, Certificate, or Registration Number	Issuing State	State	Natíonal Registry Number

CLP/CDL Applicant/Holder

○ Yes ○ No

Zip Code:

State/Province:

City:

Issuing State/Province

Driver's License Number

Signature of Driver

Address of Driver

Street:

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid Board Number. The OMB Control Number for this information collection is 21-26-0006. Public reporting for this collection of information is estimated to be approximately 20 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-IRRA, 1200 New Jersey Avenue, SE, Washington, DC. 20590.

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, <u>5 USC \$ 552a</u> AUTHORITY: Title 49, United States Code (USC), <u>49 USC 31133(a)(8)</u> and <u>31149(c)(1)(E)</u>.

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 CFB 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(ii)].

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

(or sticker)

MEDICAL RECORD #

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 <u>5 USC 552a(b)</u> 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.

CMV Driver Signature: Date:

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

PERSONAL INFORMATION										
Last Name:	First Name:		М	iddle Initial:	Date o	of Birth:	_ Age:	G	ender: (Эм О г
Address:	City:			S1	tate:	Zip Code:		Phone	e:	
Driver License Number:	State of Issue:	In –	trasi	tate Only? O Y CDL*? O Y	'es ○ No 'es ○ No	Driver ID Verified E	Ву**:			
Has your USDOT/FMCSA medical certificate ever be	peen denied or issued f	or les	s tha	an 2 years? ○ Y	es 🔾 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	on)	0	0	16. Dizziness, h	neadaches	s, numbness, tinglin	ıg, or m	emory	loss	00
2. Seizures, epilepsy		0	0	17. Unexplaine	ed weight	loss				00
3. Eye problems (except glasses or contacts)		0	0	18. Stroke, mir	ni-stroke (1	ΓΙΑ), paralysis, or we	eakness			00
4. Ear and/or hearing problems		0	0	19. Missing or	limited us	e of arm, hand, fing	er, leg,	foot, to	e	00
5. Heart disease, heart attack, bypass, or other	heart problems	0	O	20. Neck or ba	ck probler	าวร				00
6. Pacemaker, stents, implantable devices, or otl	ner heart procedures	O	O	21. Bone, musc	ele, joint, d	or nerve problems				00
7. High blood pressure		0	0	22. Blood clots	or bleedi	ng problems				00
8. High cholesterol		O	O	23. Cancer						00
9. Chronic cough, shortness of breath, or other	breathing problems	0	0	24. Chronic inf	ection or	other chronic diseas	ses			00
10: Lung disease (e.g., asthma)		Ö	O	25. Problems s	taying aw	ake, loud snoring				00
11. Kidney problems, kidney stones, or pain/pro						Carrio (gines sociale) sarama a casa carrio di nes	er trær færær it til til		*1524-05115024-9	00
12. Stomach, liver, or digestive problems		0	0	27. Have you e	ver had a	sleep test (e.g., sleep	apnea)	?		00
13. Diabetes or blood sugar problems		0	0	28. Have you e	ver spent	a night in the hospi	ital?			00
14. Anxiety, depression, nervousness, other me	ntal health problems	Ó	Ö	29. Have you e	ver been 1	treated for mental h	nealth p	roblem	ns?	0 0
15. Fainting or passing out		0	O	30. Have you e	ver had a	broken bone?				00
31. Have you ever had surgery? If "yes," please li.	st and explain below.	0	0	32. Other heal	th condition	on(s) not described	above			0 0
33. Are you currently taking medications (presc counter, herbal, diet supplements)? If "yes," ple		0	0			to any of question: those health condit			ease	00
						(Atto	ach addi	itional si	heets if n	ecessary)

Last Name:		First Name:		Middle Initial:	Date:			Page 2
DRIVER LIFESTYL	E QUESTIONS							
3F II			Yes N				+ 2	Yes No
35. Have you ever 36. Do you current	•	ow use to dacco?	0 (used an illegal subst ever failed a drug tes stance?			
DRIVER SIGNATU	RE							
		medical examiner with an Julent or intentionally false						
				Driver's Signat	ture:		Date:	
SECTION 2. Exam	ination Report (to	o be filled out by the medical	examiner)					
Review and discu	ss pertinent driv	er answers and any avail	lable medic	al records				
Comment on the dri	ver's responses to th	ne "health history" questions t	that may affe	ct the driver's safe o	peration of a commere	ial motor vehicle	(CMV).	
***************************************						(Attach ada	litional sheets	s if necessary)
FESTING						(Attach ada	litional sheets	s if necessary)
		First Name:		Middle Initial:	Height: <i>feet</i> _			
Last Name:						inches We ig		
Last Name: Neck circumferenc	e (optional)*:i	nches BMI (optional)*:	Pulse rate:	Pul	se rhythm regular: (inches Weig	ht:po	ounds
Last Name: Neck circumferenc	e (optional)*:i		Pulse rate:	Pul	se rhythm regular: (inches Weig	ht:po	ounds
Last Name: Neck circumferenc	e (optional)*:i	nches BMI (optional)*:	Pulse rate:	Pul	se rhythm regular: (inches Weig	ht:po	ounds
(Please note that a Blood Pressure Sitting	re (optional):i neck circumference	nches BMI (optional)*: e greater than 17" for men/16	Pulse rate:	Pul OR a body mass inc Urinalysis Urinalysis is re	se rhythm regular: (dex greater than 33 are Sp. Gr. equired.	inches Weig) Yes () No both risk factors	ht:po	ounds ea.)
Last Name: Neck circumference *(Please note that a	re (optional)*:i neck circumference	nches BMI (optional)*: e greater than 17" for men/16	Pulse rate:	Pul OR a body mass inc	se rhythm regular: (dex greater than 33 are Sp. Gr. equired. adings	inches Weig) Yes () No both risk factors	ht:po	ounds ea.)
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Last Name: Neck circumference *(Please note that a Blood Pressure Sitting Second reading (optional)	re (optional)*:i neck circumference	nches BMI (optional)*: e greater than 17" for men/16	Pulse rate:	Pul OR a body mass inc Urinalysis Urinalysis is re Numerical rea must be reco Protein, blood, rule out any ur Other testing	se rhythm regular: (dex greater than 33 are Sp. Gr. equired. adings rded. or sugar in the urine n nderlying medical prob	inches Weig) Yes () No both risk factors: Protein hay be an indication	ht:po for sleep apne Blood on for further	ounds ea.) Sugar
Last Name: Neck circumference *(Please note that a Blood Pressure Sitting Second reading (optional) Vision Standard is at least 2	e (optional)*:i, neck circumference Systolic	nches BMI (optional)*: e greater than 17" for men/16 Diastolic	Pulse rate: 5" for women	Pul OR a body mass inc Urinalysis Urinalysis is re Numerical ree must be reco Protein, blood, rule out any ur Other testing Hearing Standard: Must	se rhythm regular: (dex greater than 33 are Sp. Gr. equired. adings rded. or sugar in the urine n inderlying medical prob if indicated (e.g., A1C)	inches Weig) Yes () No both risk factors in the protein Protein ay be an indication lem. EKG; see FMCSA of the protein d voice at greater	ht:po for sleep apne Blood on for further guidance)	ounds ea.) Sugar r testing to
Last Name: Neck circumference *(Please note that a Blood Pressure Sitting Second reading (optional) Vision Standard is at least 2 least 70° field of vision	e (optional)*:i, neck circumference Systolic 20/40 acuity (Snelle) on in horizontal mer	nches BMI (optional)*: e greater than 17" for men/16 Diastolic n) in each eye with or withou	Pulse rate: 5" for women	Pul OR a body mass inc Urinalysis Urinalysis is re Numerical ree must be reco Protein, blood, rule out any ur Other testing Hearing Standard: Must hearing aid OR	se rhythm regular: (dex greater than 33 are Sp. Gr. equired. adings rded. or sugar in the urine n derlying medical prob if indicated (e.g., A1C) first perceive whispere average hearing loss in	inches Weig) Yes () No e both risk factors in the protein anay be an indication in the protein in the prote	ht:po for sleep apne Blood on for further guidance) than 5 feet (v	ounds ea.) Sugar r testing to with or without
Neck circumference *(Please note that a Blood Pressure Sitting Second reading (optional) Vision Standard is at least 2 least 70° field of vision rective lenses should	e (optional)*:i, neck circumference Systolic 20/40 acuity (Sneller on in horizontal mer be noted on the Me	nches BMI (optional)*: e greater than 17" for men/16 Diastolic n) in each eye with or withouridian measured in each eye. edical Examiner's Certificate.	Pulse rate: 5" for women It correction. /	Pul OR a body mass inc Urinalysis Urinalysis is re Numerical rei must be reco Protein, blood, rule out any ur Other testing Hearing Standard: Must hearing aid OR Check if hearin	se rhythm regular: (dex greater than 33 are Sp. Gr. equired. adings rded. or sugar in the urine m derlying medical prob if indicated (e.g., A1C) first perceive whispere average hearing loss in ng aid used for test:	inches Weig) Yes () No e both risk factors in the protein anay be an indication in the protein in the prote	ht:po for sleep apne Blood on for further guidance) than 5 feet (v. than 40 dB.) Left Ear ()	Sugar r testing to with or without
Last Name: Neck circumference *(Please note that a Blood Pressure Sitting Second reading (optional) Vision Standard is at least 2 least 70° field of vision	e (optional)*:i, neck circumference Systolic 20/40 acuity (Snelle) on in horizontal mer	nches BMI (optional)*: e greater than 17" for men/16 Diastolic n) in each eye with or withou	Pulse rate: 5" for women It correction. /	Pul OR a body mass inc Urinalysis Urinalysis is re Numerical rei must be reco Protein, blood, rule out any ur Other testing Hearing Standard: Must hearing aid OR Check if hearin	se rhythm regular: (dex greater than 33 are Sp. Gr. equired. adings rded. or sugar in the urine m derlying medical prob if indicated (e.g., A1C) first perceive whispere average hearing loss in ng aid used for test:	inches Weig inches Weig Protein Protein Protein Analy be an indication PEKG; see FMCSA of the content	ht:po for sleep apne Blood on for further guidance) than 5 feet (v. s. than 40 dB.) Right	ounds ea.) Sugar r testing to with or without

Left Eye: 20/ 20/____ Left Eye: ____ degrees

20/___

20/

Referred to ophthalmologist or optometrist?

Applicant can recognize and distinguish among traffic control

Received documentation from ophthalmologist or optometrist?

signals and devices showing red, green, and amber colors

Both Eyes:

Monocular vision

whispered voice can first be heard

OR

Yes No Audiometric Test Results

Right Ear Left Ear 00 500 Hz 500 Hz 1000 Hz 2000 Hz 1000 Hz 2000 Hz 00 00 Average (right): Average (left): 00

Last Name:	First Name:	M	iddle Initial:	Date:		Page
PHYSICAL EXAMINATION						
The presence of a certain conditi is readily amenable to treatment Also, the driver should be advise result in a more serious illness th	. Even if a condition does not di d to take the necessary steps to	squalify a dri	iver, the Medical	Examiner may consider of	deferring the driver tem	porarily.
Check if the body system is norn would affect the driver's ability to compensated for.						
Body System	Normal	Abnormal			Normal	Abnorma
1. General	0	0	8. Abdomen		0	0
2. Skin	0	0	9. Inguinal her	nia (male only)	0	0
3. Eyes	0	0	10. Back		0	0
4. Ears	0	0	11. Extremities	s/joints	0	0
5. Mouth/throat	0	0	12. Spine		0	0
6. Heart	0	0	13. Neuro/refl	exes	0	0
7. Lungs/chest	0	0	14. Gait		0	0
				(,	Attach additional sheets if	necessary)
MEDICAL EXAMINER DETERMI	is with it, a south to be built, as bittle, as bittle.			(,	Attach additional sheets if	necessary)
	is with it, a south to be built, as bittle, as bittle.	ate		(,	Attach additional sheets if	necessary)
MEDICAL EXAMINER DETERMI	91.41; qualifies for 2-year certific				Attach additional sheets if	necessary)
○ Meets standards in 49 CFR 39	91.41; qualifies for 2-year certific	***************************************			Attach additional sheets if	necessary)
MEDICAL EXAMINER DETERMI Meets standards in 49 CFR 35 Does not meet standards (exp Meets standards, but periodi Driver qualified for: 3 r Wearing corrective in Accompanied by a Accompanied by a Secompanied	21.41; qualifies for 2-year certifice plain why): Ic monitoring required (due to): In nonths 6 months 7 months 8 months 8 months 8 months 8 months 8 months 8 months 9 months 8 months 9 month	1 year (g aid n (<i>Driver must</i> E) certificate	other:			necessary)
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MEDICAL EXAMINER DETERMI Meets standards in 49 CFR 35 Does not meet standards (exp Meets standards, but periodi Driver qualified for: 3 r Wearing corrective l Accompanied by a Accompanied by a S Driving within an ex	21.41; qualifies for 2-year certification why): Ic monitoring required (due to): In months 6 months 7 maiver/exemption waiver/exemption (SP) It will be for mance Evaluation (SP) It will be for certification of 49 CFR 391.64 If or certification of 1 may be for certification of 1 may be for certification of 1 may be for certification. I have personal knowledge, I believe it to be true.	1 year (g aid a (Driver must E) certificate 891.62) en complete a ally reviewed are and correct	other: present exemption Medical Examine all available recent.	n certificate at time of certifi er's Certificate as stated in 4 ords and recorded inform	cation) 9 (FR 391.43(h), as approation pertaining to this	priate.

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

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: ___