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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 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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