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

33. Are you currently taking medications (prescription, over-the-counter, herbal, diet supplements)? If "yes," please describe below. Yes No

34. Did you answer "yes" to any of questions 1-30? If so, please comment further on those health conditions below. Yes No

*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?	<input type="radio"/> <input type="radio"/>	37. Have you used an illegal substance within the past 2 years?	<input type="radio"/> <input type="radio"/>
36. Do you currently drink alcohol?	<input type="radio"/> <input type="radio"/>	38. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/> <input type="radio"/>

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).

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	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting			Urinalysis is required. Numerical readings must be recorded.				
Second reading (optional)							
			<i>Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.</i> 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/ _____	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	<input type="radio"/> <input type="radio"/>
Monocular vision	<input type="radio"/> <input type="radio"/>
Referred to ophthalmologist or optometrist?	<input type="radio"/> <input type="radio"/>
Received documentation from ophthalmologist or optometrist?	<input type="radio"/> <input type="radio"/>

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
 Record distance (in feet) from driver at which a forced whispered voice can first be heard

	Right Ear	Left Ear
_____	_____	_____

OR

Audiometric Test Results

	Right Ear	Left Ear
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	<input type="radio"/>	<input type="radio"/>	8. Abdomen	<input type="radio"/>	<input type="radio"/>
2. Skin	<input type="radio"/>	<input type="radio"/>	9. Inguinal hernia (<i>male only</i>)	<input type="radio"/>	<input type="radio"/>
3. Eyes	<input type="radio"/>	<input type="radio"/>	10. Back	<input type="radio"/>	<input type="radio"/>
4. Ears	<input type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input type="radio"/>	<input type="radio"/>	12. Spine	<input type="radio"/>	<input type="radio"/>
6. Heart	<input type="radio"/>	<input type="radio"/>	13. Neuro/reflexes	<input type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input type="radio"/>	<input type="radio"/>	14. Gait	<input type="radio"/>	<input type="radio"/>

Impressions:

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: _____