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 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)*:

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____ waiver/exemption
- ☐ Driving within an exempt intracity zone (49 CFR 391.62)
- ☐ Accompanied by a Skill Performance Evaluation (SPE) certificate
- ☐ Qualified by operation of 49 CFR 391.64

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 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 License or Certificate Number

License/Certificate Issued By *(State)*

National Registry Number

Signature of Driver

Driver's License Number

License Issued By *(State)*

Intrastate Only ◯ Yes ◯ No

CDL ◯ Yes ◯ No

Address of Driver

Street: _____ City: _____ State: _____ Zip Code: _____