

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 OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 1 minute 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-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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*):

- | | |
|--|--|
| <input type="checkbox"/> Wearing corrective lenses | <input type="checkbox"/> Driving within an exempt intracity zone (49 CFR 391.62) |
| <input type="checkbox"/> Wearing hearing aid | <input type="checkbox"/> Accompanied by a Skill Performance Evaluation (SPE) certificate |
| <input type="checkbox"/> Accompanied by a _____ waiver/exemption | <input type="checkbox"/> 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 Name (*please print or type*)

Medical Examiner's License or Certificate Number

Medical Examiner's Telephone Number

Date Certificate Signed

MD Physician Assistant Advanced Practice Nurse

DO Chiropractor Other Practitioner (*specify*) _____

License/Certificate Issued By (*State*)

National Registry Number

Signature of Driver

Address of Driver

Street: _____ City: _____

Driver's License Number

License Issued By (*State*)

Intrastate Only

Yes No

CDL

Yes No

State: _____ Zip Code: _____