

**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 ( <a href="#">49 CFR 391.62</a> ) |
| <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 <a href="#">49 CFR 391.64</a>                   |

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**

\_\_\_\_\_

MD     Physician Assistant     Advanced Practice Nurse

DO     Chiropractor     Other Practitioner (*specify*) \_\_\_\_\_

**License/Certificate Issued By** (*State*)

\_\_\_\_\_

**Date Certificate Signed**

**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: \_\_\_\_\_