

Public Burden Statement

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U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

CMV Driver Medical Examination Results Form

You are required to submit the following driver medical examination data for each physical examination performed by midnight (local time) of the next calendar day.

CMV Driver Name and Address *(use Legal Name as listed on Government-Issued Identification)*

First Name: _____ Middle Name: _____ Last Name: _____ Suffix (Jr., Sr., III, etc.): _____
(enter 'NMN' if driver does not have a middle name) (optional)

Street: _____ City: _____ State/Province: _____ Zip Code: _____ E-mail: _____

CMV Driver's License Information

Number: _____ Issuing State/Province: _____ Date of Birth: _____
(use mm/dd/yyyy format)

CLP/CDL Applicant/Holder: Yes No

Examination Information *(please complete only one of the Examination Information sections below)*

Examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49): **or** Examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49), with any applicable state variances:

Examination Result: Medically Qualified
 Date MEC signed/issued: _____
(use mm/dd/yyyy format)

Medically Unqualified
 Date of examination/determination: _____
(use mm/dd/yyyy format)

Pending Determination
 Date of examination: _____
(use mm/dd/yyyy format)

Incomplete Examination
 Date of examination: _____
(use mm/dd/yyyy format)

Examination Date: _____
(use mm/dd/yyyy format)

Examination Result: Medically Qualified
 Incomplete Examination

Medical Examiner's Certificate Expiration Date: _____
(applicable when "Medically Qualified" is selected above) (use mm/dd/yyyy format)

Medical Examiner's Certificate Expiration Date: _____
(applicable when "Medically Qualified" is selected above) (use mm/dd/yyyy format)

Restrictions and Variances *(check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Wearing corrective lenses
<input type="checkbox"/> Wearing hearing aid
<input type="checkbox"/> Accompanied by a waiver/exemption
Type of waiver/exemption: <input type="checkbox"/> vision <input type="checkbox"/> diabetes <input type="checkbox"/> other
If "other," please explain: _____ | <input type="checkbox"/> Accompanied by a Skill Performance Evaluation Certificate (SPE)
<input type="checkbox"/> Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
<input type="checkbox"/> Qualified by operation of (49 CFR 391.64) (Federal)
<input type="checkbox"/> Grandfathered from State requirements (State) |
|---|--|