

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 25 minutes 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 Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: _____ Age: _____
 Street Address: _____ City: _____ State/Province: _____ Zip Code: _____
 Driver's License Number: _____ Issuing State/Province: _____ Phone: _____
 E-Mail (optional): _____ CLP/CDL Applicant/Holder*: Yes No
 Driver ID Verified By**: _____
 Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? Yes No Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**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.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. Yes No Not Sure

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below. Yes No Not Sure

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Not		Not	
	Yes	No	Yes	Sure
1. Head/brain injuries or illnesses (e.g., concussion)			16. Dizziness, headaches, numbness, tingling, or memory loss	
2. Seizures/epilepsy			17. Unexplained weight loss	
3. Eye problems (except glasses or contacts)			18. Stroke, mini-stroke (TIA), paralysis, or weakness	
4. Ear and/or hearing problems			19. Missing or limited use of arm, hand, finger, leg, foot, toe	
5. Heart disease, heart attack, bypass, or other heart problems			20. Neck or back problems	
6. Pacemaker, stents, implantable devices, or other heart procedures			21. Bone, muscle, joint, or nerve problems	
7. High blood pressure			22. Blood clots or bleeding problems	
8. High cholesterol			23. Cancer	
9. Chronic (long-term) cough, shortness of breath, or other breathing problems			24. Chronic (long-term) infection or other chronic diseases	
10. Lung disease (e.g., asthma)			25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	
11. Kidney problems, kidney stones, or pain/problems with urination			26. Have you ever had a sleep test (e.g., sleep apnea)?	
12. Stomach, liver, or digestive problems			27. Have you ever spent a night in the hospital?	
13. Diabetes or blood sugar problems Insulin used			28. Have you ever had a broken bone?	
14. Anxiety, depression, nervousness, other mental health problems			29. Have you ever used or do you now use tobacco?	
15. Fainting or passing out			30. Do you currently drink alcohol?	
			31. Have you used an illegal substance within the past two years?	
			32. Have you ever failed a drug test or been dependent on an illegal substance?	

Other health condition(s) not described above: Yes No Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: Yes No Not Sure

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of [49 CFR 390.35](#), and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under [49 CFR 390.37](#) and [49 CFR 386](#) Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

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).

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: Yes No Height: ___ feet ___ inches Weight: ___ pounds

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading <i>(optional)</i>		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Other testing if indicated

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

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/ _____	Yes No

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors

Monocular vision

Referred to ophthalmologist or optometrist?

Received documentation from ophthalmologist or optometrist?

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test:	Right Ear	Left Ear	Neither
	Right Ear	Left Ear	
Whisper Test Results			
Record distance (in feet) from driver at which a forced whispered voice can first be heard	_____	_____	_____

OR

Audiometric Test Results

Right Ear:			Left Ear:		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
_____	_____	_____	_____	_____	_____
Average (right): _____			Average (left): _____		

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 the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General			8. Abdomen		
2. Skin			9. Genito-urinary system including hernias		
3. Eyes			10. Back/spine		
4. Ears			11. Extremities/joints		
5. Mouth/throat			12. Neurological system including reflexes		
6. Cardiovascular			13. Gait		
7. Lungs/chest			14. Vascular system		

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.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

Does not meet standards (specify reason): _____

Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

Meets standards, but periodic monitoring required (specify reason): _____

Driver qualified for: 3 months 6 months 1 year other (specify): _____

Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____

Accompanied by a Skill Performance Evaluation (SPE) Certificate Qualified by operation of 49 CFR 391.64 (Federal)

Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)

Determination pending (specify reason): _____

Return to medical exam office for follow-up on (must be 45 days or less): _____

Medical Examination Report amended (specify reason): _____

(if amended) Medical Examiner's Signature: _____ Date: _____

Incomplete examination (specify reason): _____

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's Signature: _____

Medical Examiner's Name (please print or type): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date:

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):

Does not meet standards in [49 CFR 391.41](#) with any applicable State variances (*specify reason*): _____

Meets standards in [49 CFR 391.41](#) with any applicable State variances

Meets standards, but periodic monitoring required (*specify reason*): _____

Driver qualified for: 3 months 6 months 1 year other (*specify*): _____

Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (*specify type*): _____

Accompanied by a Skill Performance Evaluation (SPE) Certificate Grandfathered from State requirements (*State*)

If the driver meets the standards outlined in [49 CFR 391.41](#), with applicable State variances, then complete a Medical Examiner's Certificate, 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's Signature: _____

Medical Examiner's Name (*please print or type*): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (*specify*): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date:

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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 *(please check only one)*:
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)* **OR**
the Federal Motor Carrier Safety Regulations ([49 CFR 391.41-391.49](#)) with any applicable State variances (which will only be valid for intrastate operations), 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 Accompanied by a _____ waiver/exemption Driving within an exempt intracity zone ([49 CFR 391.62](#)) *(Federal)*
- Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate Qualified by operation of [49 CFR 391.64](#) *(Federal)*
- Grandfathered from State requirements *(State)*

Medical Examiner's Certificate Expiration Date

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name *(please print or type)*

- MD Physician Assistant Advanced Practice Nurse
- DO Chiropractor Other Practitioner *(specify)* _____

Medical Examiner's State License, Certificate, or Registration Number

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

CLP/CDL Applicant/Holder

Yes No

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