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

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

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

Other testing if indicated

### 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

**Whisper Test Results** Right Ear Left Ear

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

☐ 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: _____

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
Grandfathered from State requirements *(State)*

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 Certificate Expiration Date**

**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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