

**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:	Yes	No	Not Sure	Do you have or have you ever had:	Yes	No	Not 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  
(optional)**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
<b>Whisper Test Results</b>			
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

1. General
2. Skin
3. Eyes
4. Ears
5. Mouth/throat
6. Cardiovascular
7. Lungs/chest

**Body System**

Normal Abnormal

8. Abdomen
9. Genito-urinary system including hernias
10. Back/spine
11. Extremities/joints
12. Neurological system including reflexes
13. Gait
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: