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 is 2126-0006. Public reporting for this collection of information is estimated to be approximately 2S minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the 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:	5t	ate/Province:	Zip Co	ode:
Driver's License Number:	Issuing Sta	te/Province:		_ Phone:	
E-Mail (optional):		_ CLP/CDL Applicant/H	older*: O Yes O I	No	
		Driver ID Verified By**	•		
Has your USDOT/FMCSA medical certificate e					
*CLP/CDL Applicant/Holder: See instructions for definitions.	***	river ID Verified By: Record what type of pho	to 1D 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 O Not Sure
Are you currently taking medications (prescrip	ntion over-the-counter herbal remed	dies, diet supplements)?	C	Yes O	No O Not Sure
If "yes," please describe below.	out, over the education, no desired				
		ı			

(Attach additional sheets if necessary)

^{**}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 N	lame: _				DOB: Exam Date:			
DRIVER HEALTH HISTORY (continued)								
Do you have or have you ever had:	Ye	s N		Not Sure		Yes	No	Not Sure
1. Head/brain injuries or illnesses (e.g., concussion)	0) C)	0	16. Dizziness, headaches, numbness, tingling, or memory	0	0	0
2. Seizures/epilepsy	0) C)	0	loss	\sim	\sim	\sim
3. Eye problems (except glasses or contacts)	0) C)	0	17. Unexplained weight loss	0	0	0
4. Ear and/or hearing problems	0) C)	0	18. Stroke, mini-stroke (TIA), paralysis, or weakness	0	0	0
Heart disease, heart attack, bypass, or other heart problems	0) C)	0	19. Missing or limited use of arm, hand, finger, leg, foot, toe20. Neck or back problems	0	0	0
 Pacemaker, stents, implantable devices, or other he procedures 	art O) C)	0	21. Bone, muscle, joint, or nerve problems	0	0	0
7. High blood pressure	0) C)	0	22. Blood clots or bleeding problems	0	0	0
8. High cholesterol	0) C)	0	23. Cancer	0	-	
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	0) C)	0	24. Chronic (long-term) infection or other chronic diseases 25. Sleep disorders, pauses in breathing while asleep,	0	0	0
10. Lung disease (e.g., asthma)	0) C)	0	daytime sleepiness, loud snoring 26. Have you ever had a sleep test (e.g., sleep apnea)?	0	0	0
11. Kidney problems, kidney stones, or pain/problems	0) C)	0	27. Have you ever spent a night in the hospital?	0	ŏ	Ö
with urination	_			_	28. Have you ever had a broken bone?	0	ŏ	Ö
12. Stomach, liver, or digestive problems	Õ) (0	29. Have you ever used or do you now use tobacco?	0	Ö	0
13. Diabetes or blood sugar problems	C	_		0	•	0	ŏ	ŏ
Insulin used	0) C		0	30. Do you currently drink alcohol? 31. Have you used an illegal substance within the past	0	Ö	ŏ
 Anxiety, depression, nervousness, other mental heap problems 	eith C) C)	0	two years? 32. Have you ever failed a drug test or been dependent	0	0	0
15. Fainting or passing out	С) C)	0	on an illegal substance?	O	0	0
Did you answer "yes" to any of questions 1-32? If so, ple	ease con	nme	nt f	urthe	r on those health conditions below: O Yes O No	<u> </u>	Not	Sure
				,				
					(Attach additional she	ets if r	necess	sary)
CMV DRIVER'S SIGNATURE				la construction	utterbied is verschieden einer erstlekste die geschiede der beschied			
I certify that the above information is accurate and com	i of fraud	tuler	nt o	r inter	nat inaccurate, false or missing information may invalidate the nationally false information is a violation of 49 CFR 390.35, and	tnat s	upm	1221011
of fraudulent or intentionally false information may sub Driver's Signature:					minal penalties under <u>49 CFR 390.37</u> and <u>49 CFR 386</u> Appendi Date:	res x	anu	.
Direct 3 Digitature.							·······	
SECTION 2. Examination Report (to be filled out by the	medical	pyar	nin	er)				
DRIVER HEALTH HISTORY REVIEW	medical					(1720.00) (201.00)	1123002	isoposymi Začinich
Review and discuss pertinent driver answers and any availa	ble medi	cal re	cor	ds. Co	mment on the driver's responses to the "health history" questions th	at mo	iy affe	ect the
driver's safe operation of a commercial motor vehicle (CMV)	·.			*******				
					(Attach additional she	ets if i	neces.	sary)

OMB No.: 2126-0006	Expiration	Date: 03/31/202

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 Body System** 1. General O O S. Abdomen O O O O O O O O O O O O O O O O O O O	Last Name:	***************************************	First Name:		DOB:		Exam Date:		
Blood Pressure Systolic Diastolic Urinalysis Sp. Gr. Protein Blood Sugar Urinalysis Second reading must be recorded. Numerical readings must be recorded in the Medical Examiner's Certificate Record States 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 a corrective lenses should be noted on the Medical Examiner's Certificate Record distance (in feet) from driver at which a forced whispered voice can first be heard States (in feet) from driver at which a forced whispered voice can first be heard States (in feet) from driver at which a forced whispered voice can first be heard Noncoular vision and devices showing red, green, and amber colors Noncoular vision On Applicant can recognize and distinguish among traffic control On Applicant can recognize and distinguish among traffic control On Applicant can recognize and distinguish among traffic control On Applicant can recognize and exist and provided in the special problem. Privisical Examinar 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 condition as soon as possible, particularly if neglecting the condition as soon as possible, particularly if neglecting the condition as soon as possible, particularly if neglecting the condition as soon as possible, part	TESTING								
Second reading (coptional) Other testing if indicated Wision Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 field of vision in horizontal medialan measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Cettriciaes. Acuity Uncorrected Corrected Horizontal Field of Vision Right Eye: degrees Bight Eye: 20/ 20/ Right Eye: degrees Bight Eye: 20/ 20/ Left Eye: degrees Bight Eye: 20/ 20/ Left Eye: degrees Bight Eye: 30/ 20/ Left Eye: degrees Bight Eye: 30/ 20/ Negree, and amber colors Monocular vision Referred to ophthalmologist or optometrist? Received documentation from ophthalmologist or optometrist? Received documentation from ophthalmologist or take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition as soon as possible, particularly if neglecting the condition as 3. Eyes Normal Abnormal Rod System Normal Abnormal Second Stance (In feet) Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. Hearing Standard: Must first perceive whitspeed voice at not lies than 5 feet OR average hearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing at bearing isos of less than or equal to 40 dB, in better ear (with or without hearing a bearing isos of less than or equal to 40	Pulse Rate:	Pulse rhythm regular:	O Yes O No		Height: feetinches	Weight:	pounds		
Numerical readings (portional) Other testing if indicated Protein, blood, or supar in the urine may be an indication for further testing to rule out any underlying medical problem. Hearing Standard: Must first perceive whispered voice at not less than 5 feet OR average at team of "field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate. Actify Uncorrected Corrected Horizontal Field of Vision Right Eye: 20/ 20/ Right Eye: degrees Left Eye: 20/ 20/ Left Eye: degrees Both Eyes: 20/ 20/ Left Eye: degrees Both Eyes: 20/ 20/ Neen, and amber colors Noncoular vision Referred to ophthalmologist or optometrist? Noncoular vision Referred to ophthalmologist or optometrist? Noncoular vision Referred to ophthalmologist or optometrist? Normal Abnormal Body System Normal Abnormal Sody System Normal Sody System Normal Abnormal Sody System Normal Sody System Norma	Blood Pressure	Systolic	Diasto	olic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
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Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors Monocular vision O 500 Hz 1000 Hz 2000 Hz 500 Hz 1000 Hz 2000	Left Eye:	20/	Left Eye:	degrees	whispered voice can first b	oe heard			
Referred to ophthalmologist or optometrist? 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 Body System Normal Abnormal Body System Normal Abnormal Body System including hernias O Benito-urinary system including hernias O Benito-urinary system including reflexes O Lears O Body System including reflexes O Lears O Body System including reflexes O Lears Check the dody system including reflexes O Lears Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.	Both Eyes:	20/		Yes No	OR				
Monocular vision Referred to ophthalmologist or optometrist? Received documentation from ophthalmologist or optometrist? O Average (right): 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 Body System 1. General O B. Abdomen O O 2. Skin O G. Genito-urinary system including hernias O D Back/spine O D Back/spine				00		•	Left Ear:		
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1. General O O 8. Abdomen O O 2. Skin O O 9. Genito-urinary system including hernias O O 3. Eyes O O 10. Back/spine O O 4. Ears O O 11. Extremities/joints O O 5. Mouth/throat O O 12. Neurological system including reflexes O O 6. Cardiovascular O O 13. Gait O O 7. Lungs/chest O O 14. Vascular system O O Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.	The presence of a ce worsen, or is readily temporarily. Also, th condition could resu	ertain condition may not ne amenable to treatment. Ev e driver should be advised alt in a more serious illness	en if a condition to take the nece	n does not d essary steps	isqualify a driver, the Medica	al Examiner	may consider	· deferring	the driver ecting the
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Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.			\sim			including ii	Cilia	ŏ	ŏ
Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.	•		ŏ	ŏ				ŏ	Ŏ
Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.			Ŏ	Ŏ	_	ncluding refl	exes	Ō	Ō
Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.	6. Cardiovascular		Õ					Q	Q
			_	-	·			O	O
Enter applicable item number before each comment.	_		1 1 1 1	to whathar it	would affect the driver's ability	to operate a	CMV		

(Attach additional sheets if necessary)

Form MCSA-5875 OMB No.: 2126-0006 Expiration Date: 03/31/2025 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): O Does not meet standards (specify reason): O Meets standards in 49 CFR 391.41; qualifies for 2-year certificate O Meets standards, but periodic monitoring required (specify reason): Driver qualified for: O 3 months O 6 months O 1 year O 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) O 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: _____ O 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

City: _____ State: _____ Zip Code: _____

Medical Examiner's Certificate Expiration Date:

evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

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

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

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

Other Practitioner (specify):

National Registry Number:

Medical Examiner's Signature: ___

Medical Examiner's Address:

Form MCSA-5876 OMB No.: 2126-0006 Expiration Date: 03/31/2025

Public Burden Statement

(2)

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 is 2126-0006. Public reporting for this collection of information is estimated to be approximately one 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, 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)

						<u> </u>
I certify that I have examined Last	Name:	First Name:	in acc	cordance with	n (please check only o	ne):
•	Regulations (49 CFR 391.41-391.49) and, wit	_	•			
	Regulations (<u>49 CFR 391.41-391.49</u>) with any d, if applicable, only when <i>(check all that appl</i>)		ll only be valid for int	rastate opera	itions), and, with kno	wledge of the driving duties,
☐ Wearing corrective lenses	Accompanied by a	waiver/exemption	Driving with	hin an exemp	t intracity zone (49 C	FR 391.62) (Federal)
☐ Wearing hearing aid	☐ Accompanied by a Skill Performance E	valuation (SPE) Certificate	☐ Grandfathe	red from State	e requirements (State	e)
	garding this physical examination is true an embodies my findings completely and corr		nination Report Forr		Medical Examiner's	Certificate Expiration Date
Medical Examiner's Signature		Medical Examiı	ner's Telephone Nur	nber	Date Certificate S	igned
Medical Examiner's Name (please	print or type)	OMD O	Physician Assistant	O Advance	ed Practice Nurse	
		ODO O	Chiropractor	Other Pi	ractitioner (specify)	
Medical Examiner's State License	e, Certificate, or Registration Number	Issuing State			National Registry	Number
Driver's Signature		Driver's License	Number		Issuing State/Pro	vince
Driver's Address						CLP/CDL Applicant/Holder
Street Address:	City:	Stat	e/Province:	Zip	Code:	O Yes O No

^{**}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.**