

Public Burden Statement

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

MEDICAL EXAMINER'S CERTIFICATE

(for Commercial Driver Medical Certification)

CMV DRIVER 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 (*specify type*): _____
 - Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate
 - Driving within an exempt intracity zone ([49 CFR 391.62](#)) (*Federal*)
 - Qualified by operation of [49 CFR 391.64](#) (*Federal*)
 - 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 INFORMATION

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



CMV DRIVER INFORMATION

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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