

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined _____ in accordance with 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:

- | | |
|--|--|
| <input type="checkbox"/> wearing corrective lenses | <input type="checkbox"/> driving within an exempt intracity zone (49 CFR 391.62) |
| <input type="checkbox"/> wearing hearing aid | <input type="checkbox"/> accompanied by a Skill Performance Evaluation Certificate (SPE) |
| <input type="checkbox"/> accompanied by a _____ waiver/exemption | <input type="checkbox"/> qualified by operation of 49 CFR 391.64 |

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER**TELEPHONE****DATE****MEDICAL EXAMINER'S NAME (PRINT)**

- | | |
|--|--|
| <input type="checkbox"/> MD | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> DO | <input type="checkbox"/> Advanced Practice Nurse |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Other Practitioner |

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE**NATIONAL REGISTRY NO.****SIGNATURE OF DRIVER****INTRASTATE ONLY****CDL****DRIVER'S LICENSE NO.****STATE**

-
- YES
-
-
- NO

-
- YES
-
-
- NO

ADDRESS OF DRIVER**MEDICAL CERTIFICATION EXPIRATION DATE**