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

Medical Examination Report Form
(for Commercial Driver Medical Certification)

PRIVACY ACT STATEMENT: ***This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.***
AUTHORITY: Title 49, United States Code (USC), **49** USC 31133(a)(8) and 31149(c)(1)(E.
PURPOSE: To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State

MEDICAL RECORD #

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of F MCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].
ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.
In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses" (available at http://www.dot.gov/privacy/privacyactnotices).
ACKNOWLEDGMENT: ***I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.***

Driver's Signature_____ Date:_____

SECTION 1: Driver Information (to be filled out by the driver)

Last Name	First Name	Middle Initial	DOB:
Street Address	City	State	Zip:
Driver's License # / Issuing State	Phone		Gender:
Email (optional)		CLP/CDL Holder Yes No Not Sure	
Driver ID Verified By			
Has your USDOT/FMCSA Medical Certificate ever been denied or issued for less than 2 years? Yes No Not Sure			
**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver			
*CLP/CDL Applicant/Holder: See instructions for definitions			

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

Do you have, or have you ever had	Yes	No	Unsure		Yes	No	Unsure
1. Head/brain injuries or illnesses *(e.g., concussion)*				17. Unexplained weight loss			
2. Seizures, epilepsy				18. Stroke, mini stroke (TIA), paralysis, or weakness			
3. Eye problems *(except glasses or contacts)*				19. Missing or limited use of arm, hand, finger, leg, foot/toe			
4. Ear and/or hearing problems				20. Neck or back problems			
5. Heart disease, heart attack, bypass, or other heart problems				21. Bone, muscle, joint or nerve problems			
6. Pacemaker, stents, implantable devices, or other heart procedures				22. Blood clots or bleeding problems			
7. High blood pressure				23. Cancer			
8.High cholesterol				24. Chronic (long term) infection or other chronic diseases			
9.Chronic (long-term) cough, shortness of breath, or other breathing problems				25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring			
10. Lung Disease (e.g. Asthma)				26. Have you ever had a sleep test (e.g. sleep apnea)?			
11. Kidney problems, kidney stones or pain/problems with urination				27. Have you ever spent a night in the hospital?			
12. Stomach, liver or digestive problems				28. Have you ever had a broken bone?			
13. Diabetes or blood sugar problems Insulin Used?				29. Have you ever used, or do you now use tobacco?			

14. Anxiety, depression, nervousness or other mental health problems				30. Do you currently drink alcohol?			
15. Fainting or passing out				31. Have you used an illegal substance within the past 2 years?			
16. Dizziness, headaches, numbness, tingling, or memory loss				32. Have you ever failed a drug test or been dependent on an illegal substance?			

Other health condition(s) not described above

Did you answer Yes to any of questions 1-32? If so, please comment further on those health conditions below.

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).

TESTING

Pulse Rate Pulse Rhythm Regular - Yes No	Height = *ft:* *Inches* Weight = *pounds*
Blood Pressure: Systolic Diastolic	**Urinalysis**: SP.GR. Protein Blood Sugar
Sitting Second Reading (optional)	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 FOV
Right Eye	20/	20/	Right degrees
Left Eye	20/	20/	Left degrees
Both Eyes	20/	20/	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors Y N
Monocular Vision Y N
Referred to ophthalmologist or optometrist? Y N
Received documentation from ophthalmologist or optometrist? Y N

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).

Is Hearing Aid Used for test?			Right	Left	Neither
Whisper Test Results			Can first be heard in	Right	Left
OR					
Audiometric Test Results					
Right Ear			Left Ear		
500 hz	1000 hz	2000 hz	500 hz	1000 hx	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
General			Abdomen		
Skin			Genito-urinary system including hernias		
Eyes			Back/Spine		
Ears			Extremities/Joints		
Mouth/Throat			Neurological System including Reflexes		
Cardiovascular			Gait		
Lung/Chest			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.

MEDICAL EXAMINERS DETERMINATION (Federal)

____ 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:				

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 e)***:_____

Medical Examiners Address_____**City**_____**State**_____**Zip**_____

Medical Examiners Phone_____ **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 Examiners Certificate Expiration 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		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:				

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 e)***:_____

Medical Examiners Address_____**City**_____**State**_____**Zip**_____

Medical Examiners Phone_____ **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 Examiners Certificate Expiration Date** _____