

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: _____ Gender: ☐ M ☐ F
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

(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 Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Not				Not		
	Yes	No	Sure		Yes	No	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	☐	☐	☐	28. Have you ever had a broken bone?	☐	☐	☐
Insulin used	☐	☐	☐	29. Have you ever used or do you now use tobacco?	☐	☐	☐
14. Anxiety, depression, nervousness, 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 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
*(Attach additional sheets if necessary)***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).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse rate: _____ Pulse rhythm regular: ☐ Yes ☐ No

Height: ____ feet ____ inches Weight: ____ pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting			Urinalysis is required. Numerical readings must be recorded.				
Second reading (optional)							
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/ ____	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors ☐ Yes ☐ No

Monocular vision ☐ Yes ☐ No

Referred to ophthalmologist or optometrist? ☐ Yes ☐ No

Received documentation from ophthalmologist or optometrist? ☐ Yes ☐ No

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

Whisper Test Results

Right Ear Left Ear

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	Body System	Normal	Abnormal
1. General	☐	☐	8. Abdomen	☐	☐
2. Skin	☐	☐	9. Genito-urinary system including hernias	☐	☐
3. Eyes	☐	☐	10. Back/Spine	☐	☐
4. Ears	☐	☐	11. Extremities/joints	☐	☐
5. Mouth/throat	☐	☐	12. Neurological system including reflexes	☐	☐
6. Cardiovascular	☐	☐	13. Gait	☐	☐
7. Lungs/chest	☐	☐	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.

Mallampati Class - 1 2 3 4
 Neck Circumference (if applicable) _____ inches
 BMI - _____ Normal / Overweight / Obesity
 Body Weight - ____ restricts ability ____ does not restrict ability
 Denies excessive daytime sleepiness? Yes No Initials - _____

(Attach additional sheets if necessary)

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: Patrick Ingram, DCMedical Examiner's Name (please print or type): Patrick Ingram, DCMedical Examiner's Address: 517 Main St City: Reisterstown State: MD Zip Code: 21136Medical Examiner's Telephone Number: (410)833-3038 Date Certificate Signed: _____Medical Examiner's State License, Certificate, or Registration Number: S03384 Issuing State: MD☐ MD ☐ DO ☐ Physician Assistant ☒ Chiropractor ☐ Advanced Practice Nurse☐ Other Practitioner (specify): _____National Registry Number: 6713382780

Medical Examiner's Certificate Expiration Date: _____