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

**Medical Examiner's Certificate**  
(for Commercial Driver Medical 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
- Driving within an exempt intracity zone ([49 CFR 391.62](#)) *(Federal)*
- Wearing hearing aid
- Accompanied by a Skill Performance Evaluation (SPE) Certificate
- 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's Signature**

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**Medical Examiner's Telephone Number**

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**Date Certificate Signed**

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

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- MD       Physician Assistant       Advanced Practice Nurse
- DO       Chiropractor       Other Practitioner *(specify)* \_\_\_\_\_

**Medical Examiner's State License, Certificate, or Registration Number**

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**Issuing State**

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**National Registry Number**

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**Driver's Signature**

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**Driver's License Number**

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**Issuing State/Province**

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**Driver's Address**

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_ **CLP/CDL Applicant/Holder**

- Yes  No

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