MEDICAL EXAMINER'S CERTIFICATE

I certify 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:

- ☐ Wearing corrective lenses
- ☐ Wearing a hearing aid
- ☐ Accompanied by a __________ waiver/exemption
- ☐ Driving with an exempt intercity zone (49 CFR 391.62)
- ☐ Accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ 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 **(X)**	DATE OF MEDICAL CERTIFICATION	DOT MEDICAL CERTIFICATE EXPIRATION DATE
MEDICAL EXAMINER'S PRINTED NAME ☐ MD ☐ DO ☐ PA ☐ DC ☐ APN ☐ ________		

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NUMBER AND ISSUING STATE	NATIONAL REGISTRY NO.	MEDICAL EXAMINER'S TELEPHONE NO.

DRIVER'S LICENSE NO. AND ISSUING STATE	IS THIS A CDL?	INTRASTATE ONLY?	SIGNATURE OF DRIVER
	☐ YES ☐ NO	☐ YES ☐ NO	**(X)**

ADDRESS OF DRIVER	DRIVER'S PHONE NO.

REVISED ON 06/14

THIS CARD IS NOT FOR RESALE.