DR 2903 (04/09/12)
COLORADO DEPARTMENT OF REVENUE
1375 SHERMAN STREET
DENVER CO 80261

CDL DOT MEDICAL & SELF CERTIFICATION FORM

Federal Regulation 49 CFR 383.71 requires all CDL holders to have a DOT medical and self certification of commercial driving on file with their State Driver License Administration (SDLA). Colorado statute and rule (42-2-235 and rule 8 CCR 1507-1) requires that ALL Colorado CDL holders be medically qualified to drive a CMV by the means of a valid DOT medical or medical waiver.

Please complete this form. Incomplete or illegible forms will be rejected.

Individual's Name	Date of Birth	Colorado Driver's LIcense Number

Signature	Date

Please mark the applicable box:

☐ A. **Non-excepted Interstate** - A person must certify that he or she operates or expects to operate in interstate commerce, is both subject to and meets the qualification requirements under 49 CFR part 391 and is required to obtain a medical examiners certificate

☐ B. **Excepted Interstate** - A person must certify that he or she operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR 390.3(f), 391.2, 391.68 or 398.3.

☐ C. **Non Excepted Intrastate** – A person must certify that he or she operates only in intrastate commerce and therefore is subject to State driver qualification requirements.

☐ D. **Excepted Intrastate** – A person must certify that he or she operates in intrastate commerce but engages exclusively in transportation or operations excepted from all or parts of the State Driver qualification requirements.

TO BE COMPLETED BY MEDICAL PERSONNEL

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 when:

☐ Wearing corrective lenses

☐ Wearing hearing aid

☐ Accompanied by a _____ waiver/exemption

☐ Driving within an exempt intra city zone (49 CFR 391.62)

☐ Accompanied by as 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 form with any attachment embodies my findings completely And correctly and is on file in my office.

Signature of Medical Examiner	Telephone	Medical Certificate Issue Date

Medical Examiner's Name (Please Print)

Specialty:

☐ (MD) Medical Doctor ☐ (DO) Osteopathic Doctor ☐ (PA) Physician Assistant ☐ (AN) Advanced Practice Nurse ☐ (CO) Chiropractor

Medical Examiner's License or Certificate Number and Issuing State (Please Print)

Signature of Driver	Driver License Number	State

Address of Driver

Medical Certification Expiration Date