

INSTRUCTIONS: Write firmly

1. Lift laminate cover
2. Complete certificate

3. Remove liner from laminate
4. Apply laminate to ORIGINAL-DRIVER COPY files

5. Remove top stub and carbon
6. Distribute DRIVER and MOTOR CARRIER



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

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 1 minute 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.

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)

Medical Examiner's Certificate Expiration Date

The information I have provided regarding this physical examination is true and complete. A complete Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature

Medical Examiner's Name (please print or type)

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

Medical Examiner's Telephone Number

Date Certificate Signed

- ☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

CLP/CDL Applicant/Holder

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____ ☐ Yes ☐ No

ORIGINAL - DRIVER

MEDICAL EXAMINER'S CERTIFICATE

FOLD

DISCLAIMER: IT IS THE SOLE RESPONSIBILITY OF
THE PERSON(S) COMPLETING THIS CERTIFICATE
TO COMPLY WITH ALL REQUIREMENTS CONTAINED
IN 49 CFR PART 391 OF THE FEDERAL MOTOR
CARRIER SAFETY REGULATIONS.

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Form MCSA-5876 (Revised: 10/07/2015)

OMB No. 2126-0006 Expiration Date: 8/31/2018



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CLP/CDL Applicant/Holder

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____ ☐ Yes ☐ No

COPY - MOTOR CARRIER