Medical Examiner's Certificate

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, only when:

- ❑ wearing corrective lenses
- ❑ wearing hearing aid
- ❑ accompanied by a _____ waiver/exemption
- ❑ driving within an exempt intracity 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: _____

Telephone: (_____) _____ - _____ Ext: _____ Date: _____ / _____ / _____

Medical Examiner's Name (Print): _____

- ❑ MD
- ❑ DO
- ❑ Physician Assistant
- ❑ Chiropractor
- ❑ Advanced Practice Nurse

Medical Examiner's License or Certificate No.: _____ Issuing State: _____

Signature of Driver: _____

Driver's License No.: _____ State: _____

Address of Driver: _____

City: _____ State: _____ Zip Code: _____ - _____

Medical Certificate Expiration Date: _____ / _____ / _____