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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

PRIVACY ACT STATEMENT: This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.

AUTHORITY: Title 49, United States Code (USC), [49 USC 31133\(a\)\(8\)](#) and [31149\(c\)\(1\)\(E\)](#).

PURPOSE: To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in [49 CFR 391.41-49](#). Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in [49 CFR 391.41-49](#). To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of [49 CFR 391.41-49](#) and any variances from the physical qualification standards adopted by such State.

MEDICAL RECORD #

(or sticker)

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with [49 CFR 391.41](#). Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [\[49 CFR 391.43\(i\)\]](#).

ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under [5 USC 552a\(b\)](#) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 ([75 FR 82132](#)), under "Prefatory Statement of General Routine Uses" (available at <http://www.dot.gov/privacy/privacyactnotices>).

ACKNOWLEDGMENT: I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.

Driver's Signature:

Date:

SECTION 1. Driver Information (to be filled out by the driver)

PERSONAL INFORMATION

Last Name:	First Name:	Middle Initial:	Date of Birth:	Age:
Street Address:	City:	State/Province:	Zip Code:	
Driver's License Number:	Issuing State/Province:	Phone:	Gender: <input type="radio"/> M <input type="radio"/> F	
E-mail (optional):	<input type="radio"/> CLP Applicant* <input type="radio"/> CLP Holder* <input type="radio"/> CDL Applicant* <input type="radio"/> CDL Holder*			
Driver ID Verified By**: _____				
Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Sure				

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. Yes No Not Sure

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? Yes No Not Sure

If "yes," please describe below.

(Attach additional sheets if necessary)

Last Name:	First Name:	Middle Initial:	DOB:	Exam Date:
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DRIVER HEALTH HISTORY *(continued)*

Do you have or have your ever had:	Yes	No	Not Sure	Yes	No	Not Sure
1. Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input type="radio"/>
Insulin used	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input type="radio"/>

Other health condition(s) not described above: Yes No Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. Yes No Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of [49 CFR 390.35](#), and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under [49 CFR 390.37](#) and [49 CFR 386](#) Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name:	First Name:	Middle Initial:	DOB:	Exam Date:
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TESTING

Pulse rate:	Pulse rhythm regular: <input type="radio"/> Yes <input type="radio"/> No	Height: <i>feet</i> _____ <i>inches</i> _____	Weight: _____ <i>pounds</i>
Blood Pressure	Systolic _____ Diastolic _____	Urinalysis	Sp. Gr. _____ Protein _____ Blood _____ Sugar _____
Sitting		Urinalysis is required. Numerical readings must be recorded.	
Second reading (optional)			
Other testing if indicated		<i>Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.</i>	

Vision				Hearing			
<i>Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.</i>				<i>Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).</i>			
Acuity	Uncorrected	Corrected	Horizontal Field of Vision	Check if hearing aid used for test: <input type="radio"/> Right Ear <input type="radio"/> Left Ear <input type="radio"/> Neither			
Right Eye:	20/ _____	20/ _____	Right Eye: _____ degrees	Whisper Test Results			
Left Eye:	20/ _____	20/ _____	Left Eye: _____ degrees	Record distance (<i>in feet</i>) from driver at which a forced whispered voice can first be heard			
Both Eyes:	20/ _____	20/ _____		_____			
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors			Yes <input type="radio"/> No <input type="radio"/>	OR			
Monocular vision			<input type="radio"/> <input type="radio"/>	Audiometric Test Results			
Referred to ophthalmologist or optometrist?			<input type="radio"/> <input type="radio"/>	Right Ear		Left Ear	
Received documentation from ophthalmologist or optometrist?			<input type="radio"/> <input type="radio"/>	500 Hz	1000 Hz	2000 Hz	500 Hz 1000 Hz 2000 Hz
				Average (right): _____		Average (left): _____	

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	<input type="radio"/>	<input type="radio"/>	8. Abdomen	<input type="radio"/>	<input type="radio"/>
2. Skin	<input type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input type="radio"/>	<input type="radio"/>
3. Eyes	<input type="radio"/>	<input type="radio"/>	10. Back/Spine	<input type="radio"/>	<input type="radio"/>
4. Ears	<input type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input type="radio"/>	<input type="radio"/>	13. Gait	<input type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input type="radio"/>	<input type="radio"/>	14. Vascular system	<input type="radio"/>	<input type="radio"/>

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name:	First Name:	Middle Initial:	DOB:	Exam Date:
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Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- Does not meet standards (specify reason): _____
- Meets standards in [49 CFR 391.41](#); qualifies for 2-year certificate
- Meets standards, but periodic monitoring required (specify reason): _____
 - Driver qualified for: 3 months 6 months 1 year other (specify): _____
 - Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____
 - Accompanied by a Skill Performance Evaluation (SPE) Certificate Qualified by operation of [49 CFR 391.64](#) (Federal)
 - Driving within an exempt intracity zone (see [49 CFR 391.62](#)) (Federal)
- Determination pending (specify reason): _____
 - Return to medical exam office for follow-up on (must be 45 days or less): _____
 - Medical Examination Report amended (specify reason): _____

(if amended) Medical Examiner's Signature: _____ Date: _____
- Incomplete examination (specify reason): _____

If the driver meets the standards outlined in [49 CFR 391.41](#), then complete a Medical Examiner's Certificate as stated in [49 CFR 391.43\(h\)](#), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

Last Name:	First Name:	Middle Initial:	DOB:	Exam Date:
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MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with 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):

- Does not meet standards in [49 CFR 391.41](#) with any applicable State variances (specify reason): _____
 - Meets standards in [49 CFR 391.41](#) with any applicable State variances
 - Meets standards, but periodic monitoring required (specify reason): _____
- Driver qualified for: 3 months 6 months 1 year other (specify): _____
- Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____
- Accompanied by a Skill Performance Evaluation (SPE) Certificate Grandfathered from State requirements (State)

If the driver meets the standards outlined in [49 CFR 391.41](#), with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____