

**FOR WALLET-SIZE CARD CUT OUT ON
DOTTED LINES.**



MEDICAL EXAMINER'S CERTIFICATE I certify that I have examined		VT ONLY
(Driver's name - Print)		
In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) as revised by Vermont administrative rule and with knowledge of his/her duties, I find him/her qualified:		
<input type="checkbox"/>	only when wearing corrective lenses	
<input type="checkbox"/>	only when wearing a hearing aid	
<input type="checkbox"/>	by operation of 49 CFR 391.64	
<input type="checkbox"/>	unqualified unless accompanied by a _____ waiver	
<input type="checkbox"/>	unqualified unless driving within an exempt intracity zone	
A completed examination form for this person is on file in my office.		
Name of Medical Examiner - Print		
Title	License or Certificate #	State in which licensed
Signature of Medical Examiner		
Signature of Driver		
Address of Driver		
Issue Date	Driver's Medical Certificate Expiration Date	Area Code & Telephone # (DRIVER)