MVD - 11154
INT. 09/13

Medical Examiner's Certificate

(to be completed by medical examiner)

I certify that I have examined ______________________________ (Print driver name)
in accordance with the Federal Motor Carrier Safety regulations (49 CFR 391.41-391.49) and with knowledge of his/her driving duties, I find him/her qualified, and if applicable only when:

- ❑ wearing a hearing aid.
- ❑ wearing corrective lenses.
- ❑ Qualified by operation of 49 CFR 391.64.
- ❑ accompanied by a ________________waiver/exemption.
- ❑ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ❑ driving within an exempt intracity zone (49 CFR 391.62).

The information I have provided regarding this physical examination is true and complete. A completed examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

Printed Name of Medical Examiner | ( ) Telephone Number | Date of Examination

License/Certification Number & State | National Registry Number | Expiration Date (No more than 2 years from date of exam)

X
Signature of Medical Examiner ❑ MD ❑ DO ❑ Chiropractor ❑ Physician Assist. ❑ Adv. Practice Nurse ❑ Other Practitioner

Signature of Driver | Driver License Number | State of Issuance

Address of Driver; City, State and Zip Code