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 25 minutes 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-BRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD	#
(or sticker)	_

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

PERSONAL INFORMATION		SEP PER				YER	
Last Name:	First Name:	Middle	Initial:	Date of Birth:			Age:
Street Address:	City:		Sta	nte/Province:	▼ 7	ip Code	-
Driver's License Number:	lss	suing State/Province: _			▼ Ph	one:	
E-Mail (optional):		CLP/CDL Ap	plicant/Ho	older*: O Yes	O No		
		Driver ID Ve	rified By**:	4			
Has your USDOT/FMCSA medical certification	te ever been denied or issue	d for less than 2 years?	O Yes	O No O Not	Sure		
*CLP/CDL Applicant/Holder: See instructions for definitions.		**Driver ID Verified By: Record	what type of phot	to ID was used to verify the i	dentity of the dri	ver, e.g., CDL, i	driver's license, passport.
DRIVER HEALTH HISTORY							See
Have you ever had surgery? If "yes," please	list and explain below.				O Yes	O No	O Not Sure
Are you currently taking medications (pres	cription, over-the-counter, herb	bal remedies, diet supplem	ents)?		O Yes	O No	O Not Sure
If "yes," please describe below.			3789116.8				
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		4					

(Attach additional sheets if necessary)

Page 1

^{**}This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.**

Not you have or have you ever had: 1. Head/brain injuries or illnesses (e.g. concussion) 2. Seitzures/epilepsy 3. Eye problems (except glasses or contacts) 3. Eye problems (except glasses or contacts) 3. Eye problems (except glasses or contacts) 4. Ear and/or hearing problems 5. Heart disease, heart attack, bypass, or other heart problems 6. Pacemaker, stents, implantable devices, or other heart problems 6. Pacemaker, stents, implantable devices, or other heart procedures 7. High blood pressure 7. High blood pressure 8. High cholesterol 8. High cholesterol 9. Chronic (long-term) infection or other chronic diseases 9. Chronic (long-term) infect	Last Name: Fir	st Name:	_			DOB: Exam Date:			
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Other health condition(s) not described above: Other health conditions below: Other health conditions below:	15. Fainting or passing out		0	0	0		0	0	C
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 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: Date: CCTION 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).	Did you answer "yes" to any of questions 1-32? If so,	, please o	comr	ment	further	r on those health conditions below: O Yes O No	, 0	Not	Sur
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. Oriver's Signature: Date: Date: CECTION 2. Examination Report (to be filled out by the medical examiner) DRIVER HEALTH HISTORY REVIEW Deview 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 shee	ets if n	ecess	sary)
and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information 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. Oriver's Signature: Date: Date: Date: CCTION 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).	CMV DRIVER'S SIGNATURE	200		2 (8)	1910			STA.	
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Last Name: F			First Name: _				DOB:		_ Exam Date	e:		
TESTING	建筑比松			NO TO						Sec. Sec.		
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Sitting							is required.					
Second reading (optional)						Numerical must be re						
Other testing if	indicated			e la constitución de la constitu				n the urine may l medical problem		in for further	testing to	
At least 70° field o	st 20/40 acuity (Sne of vision in horizonta should be noted on i	ıl meridian mea	sured in each eye.	The use	on. e of			eive whispered vo or equal to 40 dB,				
Acuity	Uncorrected	Corrected	Horizontal Fie	ld of Vi	ision	Check if h	earing aid us	sed for test:	Right Ear			
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	systems for abno	rmalities.		•			2001011			**************************************	*************	
Body System				Abnor		Body Syst				Normal		
1. General 2. Skin			ŏ	õ		Abdomen Genito-urinary system including hernias				ŏ	8	
3. Eyes			ŏ	ŏ		10. Back/spine				ŏ	ŏ	
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(Attach additional sheets if necessary)

Form MCSA-5875			OMB No.: 21	126-0006 Expiration Date: 12/	/31/202
Last Name:	First Name:	DOB:	Exa	m Date:	
Please complete only one of the following (F	ederal or State) Medical	Examiner Determination sec	ctions:	14 5 4	
MEDICAL EXAMINER DETERMINATION (F	ederal)			+) L 2/1951	
Use this section for examinations performed in	accordance with the Feder	ral Motor Carrier Safety Regula	tions (49 CFR 391.41-3	91.49):	
O Does not meet standards (specify reason):					
O Meets standards in 49 CFR 391.41; qualifie	s for 2-year certificate				
O Meets standards, but periodic monitoring Driver qualified for: O 3 months O 6 m					
☐ Wearing corrective lenses ☐ Weari		To 100 h			
☐ Accompanied by a Skill Performance Ev	valuation (SPE) Certificate	Qualified by operation	AND THE COURT OF THE PROPERTY OF THE PARTY OF	. 111	
O Determination pending (specify reason):					
☐ Return to medical exam office for follow	w-up on (must be 45 days o	or less):			
☐ Medical Examination Report amended	(specify reason):				
(if amended) Medical Examiner's Signature	gnature:	Date:			
O Incomplete examination (specify reason): _					_
If the driver meets the standards outlined in	n <u>49 CFR 391.41</u> , then comp	olete a Medical Examiner's Certif	ficate as stated in 49 CFI	R 391.43(h), as appropriate.	
I have performed this evaluation for certificat evaluation, and attest that, to the best of my l Medical Examiner's Signature:	knowledge, I believe it to	be true and correct.	d recorded informatio	on pertaining to this	
Medical Examiner's Name (please print or type):					
Medical Examiner's Address:		City:	State:	Zip Code:	
Medical Examiner's Telephone Number:		Date Certificate S	igned:		1
Medical Examiner's State License, Certificate,	or Registration Number:			Issuing State:	\mathbf{v}
☐ MD ☐ DO ☐ Physician Assistant ☐ Cl ☐ Other Practitioner (specify):	niropractor	Practice Nurse			

Medical Examiner's Certificate Expiration Date:

National Registry Number: