Medical Examination Report Form
(for Commercial Motor Vehicle Operators)

SAFETY ADMINISTRATION
U.S. Department of Transportation
Federal Motor Carrier

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

AUTHORITY: Title 49, United States Code (USC), 38 USC 3113(b)(9) and 3114(a)(10).

PURPOSE: To record results of a driver's physical examination to determine qualification to operate a commercial motor vehicle (CMV) 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 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.

Examiners are required to complete the Medical Examination Report Form for every driver's 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 law enforcement agency, representative, within 48 hours after the request is made (49 CFR 391.41).

ROUTE: This is the information used for the purpose set forth above and may be verified to Federal, State, local or 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 3 USC 3521 (a) of the Privacy Act of 1974, additional disclosures may be made in accordance with the United States Department of Transportation (DOT) Privacy Statement of General Routine Uses published in the Federal Register on December 29, 2010 (F.R. 85), under "Precondition Statement of General Routine Uses" (available at http://www.dot.gov/privacy/privacystatement.html). AMENDMENT: I understand the provisions of the Privacy Act of 1974 as related to me through the abovementioned statement.

CMV Driver 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: _____ Gender: O M O F

Address: ____________________________ City: ____________________________ State: ______ Zip Code: ______ Phone: ______

Driver License Number: _______________ State of Issue: ______ Intrasrate Only? O Yes O No CDL? O Yes O No Driver ID Verified By**: ______

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? O Yes O No

DRIVER HEALTH HISTORY

1. Head/brain injuries or illnesses (e.g., concussion) O Yes O No

2. Seizures, epilepsy O Yes O No

3. Eye problems (except glasses or contacts) O Yes O No

4. Ear and/or hearing problems O Yes O No

5. Heart disease, heart attack, bypass, or other heart problems O Yes O No

6. Pacemaker, stents, implantable devices, or other heart procedures O Yes O No

7. High blood pressure O Yes O No

8. High cholesterol O Yes O No

9. Chronic cough, shortness of breath, or other breathing problems O Yes O No

10. Lung disease (e.g., asthma) O Yes O No

11. Kidney problems, kidney stones, or pain/problems with urination O Yes O No

12. Stomach, liver, or digestive problems O Yes O No

13. Diabetes or blood sugar problems O Yes O No

14. Anxiety, depression, nervousness, other mental health problems O Yes O No

15. Fainting or passing out O Yes O No

16. Dizziness, headaches, numbness, tingling, or memory loss O Yes O No

17. Unexplained weight loss O Yes O No

18. Stroke, mini-stroke (TIA), paralysis, or weakness O Yes O No

19. Missing or limited use of arm, hand, finger, leg, foot, toe O Yes O No

20. Neck or back problems O Yes O No

21. Bone, muscle, joint, or nerve problems O Yes O No

22. Blood clots or bleeding problems O Yes O No

23. Cancer O Yes O No

24. Chronic infection or other chronic diseases O Yes O No

25. Problems staying awake, loud snoring O Yes O No

26. Sleep apnea O Yes O No

27. Have you ever had a sleep test (e.g., sleep apnea)? O Yes O No

28. Have you ever spent a night in the hospital? O Yes O No

29. Have you ever been treated for mental health problems? O Yes O No

30. Have you ever had a broken bone? O Yes O No

31. Have you ever had surgery? If "yes," please list and explain below. O Yes O No

32. Other health condition(s) not described above O Yes O No

33. Are you currently taking medications (prescription, over-the-counter, herbal, diet supplements)? If "yes," please describe below. O Yes O No

34. Did you answer "yes" to any of questions 1-30? If so, please comment further on those health conditions below. O Yes O No

*CDL: Commercial Driver's License
**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 LIFESTYLE QUESTIONS**

35. Have you ever used or do you now use tobacco? Yes ☐ No ☐

36. Do you currently drink alcohol? Yes ☐ No ☐

37. Have you used an illegal substance within the past 2 years? Yes ☐ No ☐

38. Have you ever failed a drug test or been dependent on an illegal substance? Yes ☐ No ☐

**DRIVER SIGNATURE**

A driver is expected to provide the medical examiner with an accurate and complete medical history, as indicated in this Form that is part of 49 CFR 391.43. A driver who provides fraudulent or intentionally false information is in violation of 49 CFR 390.35, and would be subject to the penalties under 49 CFR 390.37.

Driver’s Signature: _______ Date: _______

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

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)*

**TESTING**

Last Name: _______ First Name: _______ Middle Initial: _______ Height: _______ feet _______ inches Weight: _______ pounds

Neck circumference (optional)*: _______ inches  BMI (optional)*: _______  Pulse rate: _______  Pulse rhythm regular: ☐ Yes ☐ No

*(Please note that a neck circumference greater than 17" for men/16" for women OR a body mass index greater than 33 are both risk factors for sleep apnea)*

Blood Pressure  Systolic  Diastolic

<table>
<thead>
<tr>
<th>Sitting</th>
<th>Second reading (optional)</th>
</tr>
</thead>
</table>

**Urinalysis**  Sp. Gr.  Protein  Blood  Sugar

Urinalysis is required.
Numerical readings must be recorded.

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.
Other testing if indicated (e.g., A1C, EKG; see FMCSA guidance)

**Vision**

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.

Acuity  Uncorrected  Corrected  Horizontal Field of Vision

| Right Eye: 20/___ 20/___ | Right Eye: ___ degrees |
| Left Eye: 20/___ 20/___ | Left Eye: ___ degrees |
| Both Eyes: 20/___ 20/___ | Yes ☐ No ☐ |

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors

Monocular vision

Referred to ophthalmologist or optometrist?

Received documentation from ophthalmologist or optometrist?

**Hearing**

Standard: Must first perceive whispered voice at greater than 5 feet (with or without hearing aid OR average hearing loss in better ear at less than 40 dB).

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results

Record distance (in feet) from driver at which a forced whispered voice can first be heard

OR

Audiometric Test Results

<table>
<thead>
<tr>
<th>Right Ear</th>
<th>Left Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>500 Hz</td>
<td>1000 Hz</td>
</tr>
<tr>
<td>2000 Hz</td>
<td>500 Hz</td>
</tr>
<tr>
<td>1000 Hz</td>
<td>2000 Hz</td>
</tr>
</tbody>
</table>

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 if the body system is normal, or if there are any abnormalities. 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. If organic disease is present, note if it has been compensated for.

<table>
<thead>
<tr>
<th>Body System</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Body System</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General</td>
<td>○</td>
<td>○</td>
<td>8. Abdomen</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. Skin</td>
<td>○</td>
<td>○</td>
<td>9. Inguinal hernia (male only)</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. Ears</td>
<td>○</td>
<td>○</td>
<td>11. Extremities/Joints</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. Mouth/throat</td>
<td>○</td>
<td>○</td>
<td>12. Spine</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**Impressions:**

(Attach additional sheets if necessary)

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**MEDICAL EXAMINER DETERMINATION**

- ○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ○ Does not meet standards (explain why): ___________________________________________________________________________
- ○ Meets standards, but periodic monitoring required (due to): ___________________________________________________________________

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other: ___________________________________________________________________
- □ Wearing corrective lenses
- □ Wearing hearing aid
- □ Accompanied by a waiver/exemption (Driver must present exemption certificate at time of certification)
- □ Accompanied by a Skill Performance Evaluation (SPE) certificate
- □ Driving within an exempt intracity zone (see 49 CFR 391.62)
- □ Qualified by operation of 49 CFR 391.64

**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 Signature: __________________________ Medical Examiner Name: __________________________ Date: __________________________

Address: __________________________ City: __________________________ State: ______ Zip Code: ______ Phone: __________________________

Medical Examiner’s License or Certificate Number: __________________________ □ MD □ DO □ Physician Assistant □ Chiropractor

State issuing License or Certificate: __________________________ □ Advanced Practice Nurse □ Other Practitioner

National Registry Number: __________________________ Medical Certificate Expiration Date: __________________________

Determination pending (specify reason): __________________________________________________________________________

Return to medical exam office for follow-up on (must be 45 days or less): __________________________________________________________________________

Comment on reasons for amendment: __________________________________________________________________________

(If amended) Medical Examiner Signature: __________________________ Date: __________________________
Medical Examiner's Certificate
(for Commercial Driver Medical Certification)

I certify that I have examined [Last Name: ] [First Name: ] in accordance with [please check only one]:

☐ 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 [check all that apply] OR

☐ 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), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when [check all that apply]:

☐ Wearing corrective lenses ☐ Accompanied by a ______ waiver/exemption
☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intrastate zone (49 CFR 391.62) (Federal)
☐ Qualified by operation of 49 CFR 391.64 (Federal)
☐ Grandfathered from State requirements (State)

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.

Medical Examiner’s Certificate Expiration Date

Signature of Medical Examiner

Medical Examiner Name (please print or type)

Medical Examiner’s State License, Certificate, or Registration Number

Medical Examiner’s Telephone Number

Date Certificate Signed

☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify)

Issuing State

National Registry Number

Signature of Driver

Driver’s License Number

Issuing State/Province

CLP/CDL Applicant/Holder

Address of Driver

City:

State/Province: _____ Zip Code: _____

☐ Yes ☐ No