

**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 one minute 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-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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

**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      Driving within an exempt intracity zone ([49 CFR 391.62](#)) *(Federal)*
- Wearing hearing aid      Accompanied by a Skill Performance Evaluation (SPE) Certificate      Qualified by operation of [49 CFR 391.64](#) *(Federal)*
- Grandfathered from State requirements *(State)*

**Medical Examiner's Certificate Expiration Date**  
\_\_\_\_\_

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

<b>Medical Examiner's Signature</b> _____	<b>Medical Examiner's Telephone Number</b> _____	<b>Date Certificate Signed</b> _____
<b>Medical Examiner's Name</b> <i>(please print or type)</i> _____	MD      Physician Assistant      Advanced Practice Nurse DO      Chiropractor      Other Practitioner <i>(specify)</i> _____	
<b>Medical Examiner's State License, Certificate, or Registration Number</b> _____	<b>Issuing State</b> _____	<b>National Registry Number</b> _____

<b>Driver's Signature</b> _____	<b>Driver's License Number</b> _____	<b>Issuing State/Province</b> _____
<b>Driver's Address</b> Street Address: _____ City: _____ State/Province: _____ Zip Code: _____		<b>CLP/CDL Applicant/Holder</b> Yes      No

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