MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined _____ in accordance with 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:

- ☐ **wearing corrective lenses**
- ☐ **wearing hearing aid**
- ☐ **accompanied by a_____ waiver/exemption**
- ☐ **driving within an exempt intracity zone (49 CFR 391.62)**
- ☐ **accompanied by a Skill Performance Evaluation Certificate (SPE)**
- ☐ **qualified by operation of 49 CFR 391.64**

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.

SIGNATURE OF MEDICAL EXAMINER	**TELEPHONE**	**DATE**

MEDICAL EXAMINER'S NAME (PRINT)	☐ **MD** ☐ **DO** ☐ **Physician Assistant** ☐ **Chiropractor** ☐ **Advanced Practice Nurse** ☐ **Other Practitioner**
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE	**NATIONAL REGISTRY NO.**

SIGNATURE OF DRIVER	**INTRASTATE ONLY**	**CDL**	**DRIVER'S LICENSE NO.**	**STATE**
	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**		

ADDRESS OF DRIVER

MEDICAL CERTIFICATION EXPIRATION DATE