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: (______) ______ - ________ Ext: __________ Date: ____ / ____ / ____

Medical Examiner's Name (Print): ____

❑ MD

❑ DO

❑ Physician Assistant

❑ Chiropractor

❑ Advanced Practice Nurse

Medical Examiner's License or Certificate No.: ______________________________ Issuing State: ____

Signature of Driver: ____

Driver's License No.: ____ State: ____

Address of Driver: ____

City: ______________________________ State: ____ Zip Code: __________-________

Medical Certificate Expiration Date: ____ / ____ / ____

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