

**Public Burden Statement**

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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)*

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**

- MD
- Physician Assistant
- Advanced Practice Nurse
- DO
- Chiropractor
- Other Practitioner *(specify)* \_\_\_\_\_

**Issuing State**

**Date Certificate Signed**

**National Registry Number**

**Signature of Driver**

**Address of Driver**

Street: \_\_\_\_\_ City: \_\_\_\_\_

**Driver's License Number**

State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Issuing State/Province**

**CLP/CDL Applicant/Holder**

Yes  No