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 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the 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 Examination Report Form (for Commercial Driver Medical Certification)

| i | MEDICAL RECORD # |
|---|------------------|
| | (or sticker) |
| | |

SECTION 1. Driver Information (to be filled out by the driver)

| and a finished the first of the company of the control of the cont | | | | <u> </u> | | |
|--|-----------------------------------|--|--|--------------------------------|---|-----------------------------|
| PERSONAL INFORMATION | | A second transfer to the second | Translation (Contract) | Men de t | | |
| Last Name: | | | | | | |
| Street Address: | City: | | State/Pro | vince: | Zip Code | 2; |
| Driver's License Number: | | | | | | |
| E-Mail (optional): | | | | | | |
| | | | rified By**: | | | |
| Has your USDOT/FMCSA medical certific | cate ever been denied or issu | | | | ······································ | |
| *CLP/CDL Applicant/Holder: See instructions for definitions. | | **Driver ID Verified By: Record | what type of photo ID was use | ed to verify the identity of t | he driver, e.g., CDL, | driver's license, passport. |
| DRIVER HEALTH HISTORY | Teacher and the second | THE PROPERTY OF THE PARTY OF TH | The State of the Land | | (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) | |
| Have you ever had surgery? If "yes," plea | se list and explain below. | | | OY | es O No | O Not Sure |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Are you currently taking medications (pr If "yes," please describe below. | rescription, over-the-counter, he | erbal remedies, diet supplem | ents)? | O Y | es O No | O Not Sure |
| | | | ······································ | | · · · · · · · · · · · · · · · · · · · | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

(Attach additional sheets if necessary)

^{**}This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.**

| Last Name: | First Name | : | | | DOB: Exam Date: | | | |
|--|---|----------|---------------|-------------|--|---|--------|-------------|
| DRIVER HEALTH HISTORY (continued) | | | | | STATE CONTRACTOR OF THE STATE O | A 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | |
| Do you have or have you ever had: | MARKET LIBRARY | Yes | No | Not Sure | | Yes | No | Not Sure |
| 1. Head/brain injuries or illnesses (e.g., concu | ssion) | 0 | 0 | 0 | 16. Dizziness, headaches, numbness, tingling, or memory | 0 | 0 | 0 |
| 2. Seizures/epilepsy | | 0 | 0 | 0 | loss 17. Unexplained weight loss | ^ | ^ | _ |
| 3. Eye problems (except glasses or contacts) | | 0 | 0 | 0 | 18. Stroke, mini-stroke (TIA), paralysis, or weakness | 0 | 0 | 0 |
| 4. Ear and/or hearing problems | | 0 | 0 | 0 | 19. Missing or limited use of arm, hand, finger, leg, foot, toe | 0 | 0 | 0 |
| 5. Heart disease, heart attack, bypass, or oth problems | er heart | 0 | 0 | 0 | 20. Neck or back problems | 00 | 00 | 00 |
| 6. Pacemaker, stents, implantable devices, o | r other heart | 0 | 0 | 0 | 21. Bone, muscle, joint, or nerve problems | Õ | Õ | Õ |
| procedures 7. High blood pressure | | \sim | _ | \sim | 22. Blood clots or bleeding problems | Ŏ | Ŏ | Ŏ |
| 8. High cholesterol | | 0 | 0 | 0 | 23. Cancer | Ŏ | Õ | Õ |
| 9. Chronic (long-term) cough, shortness of b | roath ar | 0 | 0 | 0 | 24. Chronic (long-term) infection or other chronic diseases | Ö | Ŏ | Õ |
| other breathing problems | reath, or | 0 | 0 | 0 | 25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring | ŏ | Ö | ŏ |
| 10. Lung disease (e.g., asthma) 11. Kidney problems, kidney stones, or pain/s | | 0 | 0 | 0 | 26. Have you ever had a sleep test (e.g., sleep apnea)? | 0 | 0 | 0 |
| with urination | problems | 0 | 0 | O | 27. Have you ever spent a night in the hospital? | Õ | ŏ | Õ |
| 12. Stomach, liver, or digestive problems | | 0 | 0 | 0 | 28. Have you ever had a broken bone? | Ŏ | Õ | Õ |
| 13. Diabetes or blood sugar problems | | 0 | 0 | Ö | 29. Have you ever used or do you now use tobacco? | Õ | Ŏ | Õ |
| Insulin used | | 0 | 0 | 0 | 30. Do you currently drink alcohol? | Ŏ | Ō | Õ |
| 14. Anxiety, depression, nervousness, other n problems | nental health | 0 | 0 | 0 | 31. Have you used an illegal substance within the past two years? | 0 | Ō | Ö |
| 15. Fainting or passing out | | 0 | 0 | 0 | 32. Have you ever failed a drug test or been dependent on an illegal substance? | 0 | 0 | 0 |
| Did you answer "yes" to any of questions 1-32 | ? If so, please c | comn | nent | further | on those health conditions below: O Yes O No | 0 | Not | Sure |
| SCHOOL STREET, | Control of the second of the second | Pristate | flucion de ha | | (Attach additional shee | ts if n | ecesso | ary) |
| I and my medical examiner 5 certificate, that su | omission of fra | wani | ent o | r inten | at inaccurate, false or missing information may invalidate the tionally false information is a violation of <u>49 CFR 390.35</u> , and t inal penalties under <u>49 CFR 390.37</u> and <u>49 CFR 386</u> Appendic Date: | exam | inatio | |
| SECTION 2. Examination Report (to be filled o | out by the medic | alex | amina | or) | | | | |
| DRIVER HEALTH HISTORY REVIEW | ASSESSED AND AND AND AND AND AND AND AND AND AN | e e | an in in | | | e control | | |
| Review and discuss pertinent driver answers and a | ny available me | edical | record | ds. Corr | nment on the driver's responses to the "health history" questions tha | it may | affec | ct the |
| driver's safe operation of a commercial motor vehi | cie (CMV). | · | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | (Attach additional shee | ts if ne | ecesso | zry) |

| | | | | | VIVID : | MO:: X X0-UUUD | Expiration | Date: 03/31/20 |
|---|--|---|-------------------------|---|------------------------------------|---|--------------------------------------|--|
| Last Name: | | First Name: | | DOB: | | Exam Date: | | |
| TESTING | y graenou, enconcreta po Para de la companya de | | | | | | | |
| Pulse Rate: | Pulse rhythm regular: | O Yes O No | | Height:feetinches | Welght: _ | pounds | | I MATERIAL PROPERTY OF STREET |
| Blood Pressure | Systolic | Diastolic | • | Urinalysis | Sp. Gr. | Protein | Blood | Sugar |
| Sitting | | | | Urinalysis is required. | | | | T |
| Second reading (optional) | | | | Numerical readings must be recorded. | | | | |
| Other testing if indicat | ted | 31 | | Protein, blood, or sugar in the | e urine may b | e an indication | n for further | testina to |
| | | | | rule out any underlying medi | ical problém. | | | |
| At least 70° field of vision |) aculty (Snellen) in each eye in horizontal meridian mea: se noted on the Medical Exar | sured in each eve. The | ection. e use of | Hearing Standard: Must first perceive w hearing loss of less than or eq | whispered voic ual to 40 dB, ii | ce at not less th n better ear (wi | an 5 feet O i th or withou | R average ut hearing aid): |
| Acuity Un | corrected Corrected | Horizontal Field o | of Vision | Check if hearing aid used t | for test: | Right Ear 🔲 | Left Ear Γ | 7 Neither |
| Right Eye: 20/ | / 20/ | Right Eye: | degrees | Whisper Test Results | | | Right I | ar Left Ear |
| Left Eye: 20 | / 20/ | Left Eye: | degrees | Record distance (in feet) fro whispered voice can first b | om driver at | which a force | ed | |
| Both Eyes: 20/ | / 20/ | , | Yes No | OR | Jenedia | | | ************************************** |
| Applicant can recognize signals and devices should be signals. | ze and distinguish among owing red, green, and am | traffic control | 00 | Audiometric Test Results Right Ear: | • | Left Ear: | | |
| Monocular vision | | | 00 | | 000 Hz | | 1000 Hz | 2000 Hz |
| | ologist or optometrist? | | 00 | v | - | *************************************** | | |
| Received documentati | on from ophthalmologist | or optometrist? | 00 | Average (right): | | Average (left | t): | |
| temporarily. Also, the c condition could result Check the body system | ain condition may not ne nenable to treatment. Evi driver should be advised in a more serious illness t | to take the necessa hat might affect d | ary steps to riving. | particularly if the condition equalify a driver, the Medica o correct the condition as so | | | | |
| Body System 1. General | | Normal Ab | | Body System | | | Normal | Abnormal |
| 2. Skin | | 0000000 | 0 | 8. Abdomen 9. Genito-urinary system | includina he | ernias | 0000000 | 9 |
| 3. Eyes 4. Ears | | 0 | 00000 | 10. Back/spine | - | | ŏ | ŏ |
| 5. Mouth/throat | | ŏ | ŏ | 11. Extremities/joints12. Neurological system in | cluding refle | SVAC | 8 | 0 |
| 6. Cardiovascular 7. Lungs/chest | | Ŏ | Ŏ | 13. Gait | clading (CI) | -//03 | ŏ | 000000 |
| Discuss any abnormal ar | nswers in detail in the space mber before each comment | below and indicate v | whether it v | 14. Vascular system yould affect the driver's ability | to operate a (| IMV. | 0 | 0 |
| | THE PERMETCHAIL COMMENT | | | | | | | |
| | * | | | | | | | |
| | | | | | | | | |
| | | 9 c | | | | | | |
| | | | | | | | | |
| | | | 1 | | | | | |

(Attach additional sheets if necessary)

| | and the second s | | WIND HOW A I AU-DUOU EAPI | rativii Pate: V5/3 (/20. |
|---|--|---|--|---|
| Last Name: | First Name: | DOB: | Exam Date: | |
| Please complete only one of the follo | owing (Federal or State) Medical Ex | | | |
| MEDICAL EXAMINER DETERMINA | TION (Federal) | NAME OF THE PARTY | | |
| Use this section for examinations perfo | rmed in accordance with the Federal | Motor Carrier Safety Regulation | ns (49 CFR 391.41-391.49): | 400年2月1日 100年11日 |
| O Does not meet standards (specify r | | | | |
| O Meets standards in 49 CFR 391.41 | | , | | |
| O Meets standards, but periodic mo | | | | |
| Driver qualified for: O 3 months | O 6 months O 1 year O other | r (specify); | | |
| ☐ Wearing corrective lenses | ☐ Wearing hearing aid ☐ Acco | ompanied by a waiver/exempt | ion (specify type): | |
| ☐ Accompanied by a Skill Perform | nance Evaluation (SPE) Certificate | Qualified by operation of | 49 CFR 391.64 (Federal) | |
| ☐ Driving within an exempt intra | city zone (see <u>49 CFR 391.62</u>) (Federal |) | The state of the s | |
| O Determination pending (specify red | ason); | | | 2 |
| Return to medical exam office | for follow-up on (must be 45 days or le | ess): | | And to a state of the state of |
| ☐ Medical Examination Report a | mended (specify reason): | | | |
| (if amended) Medical Exam | iner's Signature: | Date: | | |
| O Incomplete examination (specify re | ason): | | | |
| If the driver meets the standards o | utlined in <u>49 CFR 391.41</u> , then comple | te a Medical Examiner's Certifica | te as stated in <u>49 CFR 391.43(h)</u> , a | s appropriate. |
| I have performed this evaluation for c evaluation, and attest that, to the bes | ertification. I have personally review | and all available research and a | | |
| Medical Examiner's Signature: | , | | | |
| Medical Examiner's Name (please print | | | | |
| Medical Examiner's Address: | | City: | State: Tin C | ode: |
| Medical Examiner's Telephone Numb | er: | Date Certificate Sign | ed: | |
| Medical Examiner's State License, Cer | tificate, or Registration Number: | | lscula | - Ct-sto. |
| ☐ MD ☐ DO ☐ Physician Assistan | nt Chiropractor Advanced Pr | actice Nurse | issum | j state: |
| Other Practitioner (specify): | | | | |
| | | | | |

Medical Examiner's Certificate Expiration Date:

National Registry Number:

OMB No.: 2126-0006 Expiration Date: 03/31/2025

Form MCSA-5876

Public Burden Statement

| A rederal 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 of information of information is estimated to be approximately one minute per responsibility of this collection of information are mandatory. Sand comments regarding this burden estimate or any including suggestions for reducing this burden to: Information Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590. | 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 set for this information collection is 21.26-0006. Public reporting for this collection of information is estimated to be approximately one minute per response, wing the collection of information. All responses to this collection of information, Send comments regarding this burden estimate or any ormation Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590. | rwork Reduction Act unless ately one minute per response, his burden estimate or any shington, D.C. 20590. |
|--|---|---|
| U.S. Department of Transportation Federal Motor Carrier Safety Administration (for Commen | Medical Examiner's Certificate (for Commercial Driver Medical Certification) | |
| I certify that I have examined Last Name: | in accordance with (please check only one): | |
| Othe 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 Othe 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): | of the driving duties, I find this person is qualified, and, if applicable, only when ($ch_{\rm c}$ ate variances (which will only be valid for intrastate operations), and, with knowled | all that apply) OR of the driving duties, |
| ■ Wearing corrective lenses ■ Accompanied by a Skill Performance Evaluation (SPE) Certificate | waiver/exemption Driving within an exempt intracity zone (49 CFR 391.62) (Federal) Certificate Qualified by operation of 49 CFR 391.64 (Federal) Grandfathered from State requirements (State) | . <u>52</u>) (Federal) |
| 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. | Omplete Medical Examination Report Form, file in my office. | cate Expiration Date |
| | | |
| Medical Examiner's Signature | Medical Examiner's Telephone Number Date Certificate Signed | |
| Medical Examiner's Name (please print or type) | OMD O Physician Assistant O Advanced Practice Nurse | |
| Medical Examiner's State License, Certificate, or Registration Number | State | |
| | | |
| Driver's Signature | Driver's License Number Issuing State/Province | |
| Driver's Address | 4TD | CLP/CDL Applicant/Holder |

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

O Yes O No

Zip Code:

State/Province:

Street Address: