

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)*

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.

Medical Examiner's Signature

Medical Examiner's Name *(please print or type)*

Medical Examiner's State License, Certificate, or Registration Number

Medical Examiner's Telephone Number

Date Certificate Signed

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

Issuing State

National Registry Number

Driver's Signature

Driver's Address

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____ Yes No

Driver's License Number

Issuing State/Province

CLP/CDL Applicant/Holder

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