

**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      Grandfathered from State requirements *(State)*

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 Certificate Expiration Date**  
\_\_\_\_\_

**Medical Examiner's Signature**

**Medical Examiner's Telephone Number**

**Date Certificate Signed**

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

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

\_\_\_\_\_  
**Medical Examiner's State License, Certificate, or Registration Number**

\_\_\_\_\_  
**Issuing State**

\_\_\_\_\_  
**National Registry Number**

**Driver's Signature**

**Driver's License Number**

**Issuing State/Province**

**Driver's Address**

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_ **CLP/CDL Applicant/Holder**

Yes      No

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