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U.S. Department of Transportation  
Federal Motor Carrier  
Safety Administration

**Medical Examination Report Form**  
(for Commercial Driver Medical Certification)

**MEDICAL RECORD #**

\_\_\_\_\_  
(or sticker)

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

**PERSONAL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Issuing State/Province: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail (optional): \_\_\_\_\_ CLP/CDL Applicant/Holder\*:  Yes  No

Driver ID Verified By\*\*: \_\_\_\_\_

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years?  Yes  No  Not Sure

\*CLP/CDL Applicant/Holder: See instructions for definitions.

\*\*Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

**DRIVER HEALTH HISTORY**

Have you ever had surgery? If "yes," please list and explain below.  Yes  No  Not Sure

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below.  Yes  No  Not Sure

(Attach additional sheets if necessary)

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**DRIVER HEALTH HISTORY** *(continued)*

Do you have or have you ever had:	Not				Not		
	Yes	No	Sure		Yes	No	Sure
1. Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Seizures/epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems Insulin used	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other health condition(s) not described above:  Yes  No  Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below:  Yes  No  Not Sure

*(Attach additional sheets if necessary)*

**CMV DRIVER'S SIGNATURE**

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of [49 CFR 390.35](#), and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under [49 CFR 390.37](#) and [49 CFR 386](#) Appendices A and B.

Driver's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 2. Examination Report** *(to be filled out by the medical examiner)*

**DRIVER HEALTH HISTORY REVIEW**

*Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).*

*(Attach additional sheets if necessary)*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**TESTING**

Pulse Rate: \_\_\_\_\_ Pulse rhythm regular:  Yes  No Height: \_\_\_ feet \_\_\_ inches Weight: \_\_\_ pounds

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading <i>(optional)</i>		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Other testing if indicated

*Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.*

**Vision**  
Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/ _____	20/ _____	Right Eye: _____ degrees
Left Eye:	20/ _____	20/ _____	Left Eye: _____ degrees
Both Eyes:	20/ _____	20/ _____	

- |  | Yes                   | No                    |
|--|-----------------------|-----------------------|
| Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors | <input type="radio"/> | <input type="radio"/> |
| Monocular vision   | <input type="radio"/> | <input type="radio"/> |
| Referred to ophthalmologist or optometrist?  | <input type="radio"/> | <input type="radio"/> |
| Received documentation from ophthalmologist or optometrist?  | <input type="radio"/> | <input type="radio"/> |

**Hearing**  
Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test:  Right Ear  Left Ear  Neither

**Whisper Test Results** Right Ear Left Ear  
Record distance (in feet) from driver at which a forced whispered voice can first be heard \_\_\_\_\_

**OR**

**Audiometric Test Results**

Right Ear:				Left Ear:			
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz		
_____	_____	_____	_____	_____	_____		
Average (right): _____			Average (left): _____				

**PHYSICAL EXAMINATION**

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	<input type="radio"/>	<input type="radio"/>	8. Abdomen	<input type="radio"/>	<input type="radio"/>
2. Skin	<input type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input type="radio"/>	<input type="radio"/>
3. Eyes	<input type="radio"/>	<input type="radio"/>	10. Back/spine	<input type="radio"/>	<input type="radio"/>
4. Ears	<input type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input type="radio"/>	<input type="radio"/>	13. Gait	<input type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input type="radio"/>	<input type="radio"/>	14. Vascular system	<input type="radio"/>	<input type="radio"/>

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**Please complete only one of the following (Federal or State) Medical Examiner Determination sections:****MEDICAL EXAMINER DETERMINATION (Federal)***Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):*

- Does not meet standards (specify reason): \_\_\_\_\_
- Meets standards in [49 CFR 391.41](#); qualifies for 2-year certificate
- Meets standards, but periodic monitoring required (specify reason): \_\_\_\_\_  
 Driver qualified for:  3 months  6 months  1 year  other (specify): \_\_\_\_\_
- Wearing corrective lenses  Wearing hearing aid  Accompanied by a waiver/exemption (specify type): \_\_\_\_\_
- Accompanied by a Skill Performance Evaluation (SPE) Certificate
- Driving within an exempt intracity zone (see [49 CFR 391.62](#)) (Federal)
- Determination pending (specify reason): \_\_\_\_\_
- Return to medical exam office for follow-up on (must be 45 days or less): \_\_\_\_\_
- Medical Examination Report amended (specify reason): \_\_\_\_\_  
 (if amended) Medical Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_
- Incomplete examination (specify reason): \_\_\_\_\_

**If the driver meets the standards outlined in [49 CFR 391.41](#), then complete a Medical Examiner's Certificate as stated in [49 CFR 391.43\(h\)](#), as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: \_\_\_\_\_

Medical Examiner's Name (please print or type): Michael Scott Johnson, DCMedical Examiner's Address: 211 East Franklin Street, Suite C (PO Box 706) City: Hillsboro State: TX Zip Code: 76645Medical Examiner's Telephone Number: (254) 580-0701 Date Certificate Signed: \_\_\_\_\_Medical Examiner's State License, Certificate, or Registration Number: DC08958 Issuing State: TX MD  DO  Physician Assistant  Chiropractor  Advanced Practice Nurse Other Practitioner (specify): \_\_\_\_\_National Registry Number: 1874510734Medical Examiner's Certificate Expiration Date:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**MEDICAL EXAMINER DETERMINATION (State)**

*Use this section for examinations performed in accordance with 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):*

- Does not meet standards in [49 CFR 391.41](#) with any applicable State variances (specify reason): \_\_\_\_\_
- Meets standards in [49 CFR 391.41](#) with any applicable State variances
- Meets standards, but periodic monitoring required (specify reason): \_\_\_\_\_  
 Driver qualified for:  3 months  6 months  1 year  other (specify): \_\_\_\_\_
- Wearing corrective lenses  Wearing hearing aid  Accompanied by a waiver/exemption (specify type): \_\_\_\_\_
- Accompanied by a Skill Performance Evaluation (SPE) Certificate  Grandfathered from State requirements (State)

**If the driver meets the standards outlined in [49 CFR 391.41](#), with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: \_\_\_\_\_

Medical Examiner's Name (please print or type): Michael Scott Johnson, DC

Medical Examiner's Address: 211 East Franklin Street, Suite C (PO Box 706) City: Hillsboro State: TX Zip Code: 76645

Medical Examiner's Telephone Number: (254) 580-0701 Date Certificate Signed: \_\_\_\_\_

Medical Examiner's State License, Certificate, or Registration Number: DC08958 Issuing State: TX

MD  DO  Physician Assistant  Chiropractor  Advanced Practice Nurse

Other Practitioner (specify): \_\_\_\_\_

National Registry Number: 1874510734

Medical Examiner's Certificate Expiration Date: