Public Burden Systemant

A Federal agency may not conduct or sponsor, and a person is not respond to respend to respend to person be subject to a person for failure to comply with a collection of information subject to the requirements of the Paperson's Reduction Act uniformation that collection is 2126-0006. Public reporting for this collection of information is estimated in the appreciations of information is estimated in the appreciationship 25 interests per requirements requirements requirements of information is estimated in the appreciation of information. Easier of information and reviewing the collection of information. All responses the collection of information are insolvances; bend commences requirements every other expect of this collection of information, including suggestions for reducing this burden estimation of this collection of information, including suggestions for reducing this burden is solven in the collection of information including suggestions for reducing this burden is solven.

Settlemantion Collection Classrance (Office), Pederal Moore Carrier Safety Administration, MC-684, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICA	L RECORD #
(or	sticker)

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

PERSONAL INFORMATION			din the		
Last Name:	First Name:	Middle Initial: Date of	Birth:		Age:
Street Address:	City:	State/Provin	ce: Z	ip Code	
Driver's License Number:					
E-Mail (optional):		CLP/CDL Applicant/Holder*: C	Yes O No		
		Driver ID Verified By**:			
Has your USDOT/FMCSA medical certification	te ever been denied or issued for				
*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 dri	ver, e.g., CDL,	driver's license, passport.
DRIVER HEALTH HISTORY					
Have you ever had surgery? If "yes," please	list and explain below.		O Yes	O No	O Not Sure
Are you currently taking medications (pres) If "yes," please describe below.	scription, over-the-counter, herbal re	medies, diet supplements)?	O Yes	O No	O Not Sure

(Attach additional sheets if necessary)

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Form MCSA-5815

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

DRIVER HEALTH HISTORY	sst Name: First Name:		DOB: Exam Date:				
	10		Not		Ves	No	Not
to you have or have you ever had:	Yes	No	Sure		_	-	_
 Head/brain injuries or illnesses (e.g., concussion) 	0	0	0	 Dizziness, headaches, numbness, tingling, or memory loss 	0	0	0
2. Seizures/epilepsy	0	0	0	17. Unexplained weight loss	0	0	0
3. Eye problems (except glasses or contacts)	0	0	0	18. Stroke, mini-stroke (TIA), paralysis, or weakness	0	O	0
Ear and/or hearing problems	0	0	0	19. Missing or limited use of arm, hand, finger, leg, foot, toe	O	O	O
 Heart disease, heart attack, bypass, or other heart problems 	0	0	0	20. Neck or back problems	O	0	0
 Pacemaker, stents, implantable devices, or other heart procedures 	0	0	0	21. Bone, muscle, joint, or nerve problems	0	00	0
7. High blood pressure	0	0	0	22. Blood clots or bleeding problems	O	ŏ	O
B. High cholesterol	0	O	0	23. Cancer	ŏ	ŏ	ŏ
). Chronic (long-term) cough, shortness of breath, or other breathing problems	Õ	o	O	 Chronic (long-term) infection or other chronic diseases Sleep disorders, pauses in breathing while asleep, 	0	0	0
D. Lung disease (e.g., asthma)	0	0	0	daytime sleepiness, loud snoring	0	0	0
Kidney problems, kidney stones, or pain/problems	0	0	Õ	26. Have you ever had a sleep test (e.g., sleep apnea)?	_	0	0
with urination	0	0	0	27. Have you ever spent a night in the hospital?	0		
2. Stomach, liver, or digestive problems	0	0	0	28. Have you ever had a broken bone?	0	0	0
3. Diabetes or blood sugar problems	0	0	0	29. Have you ever used or do you now use tobacco?	0	0	C
Insulin used	0	0	0	30. Do you currently drink alcohol?	0	0	C
 Anxiety, depression, nervousness, other mental health problems 	0	0	0	31. Have you used an illegal substance within the past two years?	0	0	C
5. Fainting or passing out	0	0	0	32. Have you ever failed a drug test or been dependent on an illegal substance?	0	0	C
id you answer "yes" to any of questions 1-32? If so, please	com	men	t furthe	er on those health conditions below: O Yes O N	10 () No	t Su
id you answer "yes" to any of questions 1-32? If so, please	e com	men	t furthe				
	e com	men	t furthe	er on those health conditions below: O Yes O N			
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