


Please note, the expiration date on this form relates to the process for renewing the Information Collection Request that includes this form with the Office of Management and Budget. This requirement to collect information as requested on this form does not expire.



Public Burden Statement
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 one minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this 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 EXAMINER’S CERTIFICATE
(for Commercial Driver Medical Certification)

CMV DRIVER 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 *(specify type)*: _____

☐ 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 INFORMATION

Medical Examiner’s Signature	Medical Examiner’s Telephone Number	Date Certificate Signed
_____	_____	_____
Medical Examiner’s Name <i>(please print or type)</i>	<div><input type="radio"/> MD <input type="radio"/> Physician Assistant <input type="radio"/> Advanced Practice Nurse</div> <div><input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> Other Practitioner <i>(specify)</i></div>	
_____ /WORKRIGHT CLINIC 708-579-4900		
Medical Examiner’s State License, Certificate, or Registration Number	Issuing State	National Registry Number
_____	_____	_____

CMV DRIVER INFORMATION

Driver’s Signature	Driver’s License Number	Issuing State/Province
_____	_____	_____
Driver’s Address	CLP/CDL Applicant/Holder	
Street Address: _____ City: _____ State/Province: _____ Zip Code: _____	<input type="radio"/> Yes <input type="radio"/> No	