Form MCSA-5876 **OMB No.: 2126-0006 Expiration Date: 03/31/2025**

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.

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 *(please print or type)*
/WORKRIGHT CLINIC 708-579-4900

◯ 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**

CMV DRIVER INFORMATION

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