

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 25 minutes 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: Medical Programs Division, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

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)	☐	☐	☐	16. Dizziness, headaches, numbness, tingling, or memory loss	☐	☐	☐
2. Seizures/epilepsy	☐	☐	☐	17. Unexplained weight loss	☐	☐	☐
3. Eye problems (except glasses or contacts)	☐	☐	☐	18. Stroke, mini-stroke (TIA), paralysis, or weakness	☐	☐	☐
4. Ear and/or hearing problems	☐	☐	☐	19. Missing or limited use of arm, hand, finger, leg, foot, toe	☐	☐	☐
5. Heart disease, heart attack, bypass, or other heart problems	☐	☐	☐	20. Neck or back problems	☐	☐	☐
6. Pacemaker, stents, implantable devices, or other heart procedures	☐	☐	☐	21. Bone, muscle, joint, or nerve problems	☐	☐	☐
7. High blood pressure	☐	☐	☐	22. Blood clots or bleeding problems	☐	☐	☐
8. High cholesterol	☐	☐	☐	23. Cancer	☐	☐	☐
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	☐	☐	☐	24. Chronic (long-term) infection or other chronic diseases	☐	☐	☐
10. Lung disease (e.g., asthma)	☐	☐	☐	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	☐	☐	☐
11. Kidney problems, kidney stones, or pain/problems with urination	☐	☐	☐	26. Have you ever had a sleep test (e.g., sleep apnea)?	☐	☐	☐
12. Stomach, liver, or digestive problems	☐	☐	☐	27. Have you ever spent a night in the hospital?	☐	☐	☐
13. Diabetes or blood sugar problems	☐	☐	☐	28. Have you ever had a broken bone?	☐	☐	☐
Insulin used	☐	☐	☐	29. Have you ever used or do you now use tobacco?	☐	☐	☐
14. Anxiety, depression, nervousness, other mental health problems	☐	☐	☐	30. Do you currently drink alcohol?	☐	☐	☐
15. Fainting or passing out	☐	☐	☐	31. Have you used an illegal substance within the past two years?	☐	☐	☐
				32. Have you ever failed a drug test or been dependent on an illegal substance?	☐	☐	☐

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)

Form MCSA-5876		OMB No.: 2126-0006		Expiration Date: 03/31/2028	
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: Medical Programs Division, Federal Motor Carrier Safety Administration, 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)			
I certify that I have examined <i>(last name)</i> _____ <i>(first name)</i> _____ in accordance with <i>(please check only one)</i> : ☐ 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 <i>(check all that apply)</i> 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 ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption (specify type) _____ ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal) ☐ 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 <i>(please print or type)</i> _____ /WORKRIGHT CLINIC 708-579-4900		☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse ☐ DO ☐ Chiropractor ☐ Other Practitioner <i>(specify)</i> _____			
Medical Examiner's State License, Certificate, or Registration Number		Issuing State		National Registry Number	
Driver's Signature X		Driver's License Number		Issuing State/Province	
Driver's Address Street Address: _____ City: _____ State/Province: _____ Zip Code: _____				CLP/CDL Applicant/Holder ☐ Yes ☐ No	
This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements. WORKRIGHT OCCUPATIONAL HEALTH SERVICES 708-579-4900 Rev 3/27/25					

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: ☐ Yes ☐ No Height: _____ feet _____ inches Weight: _____ pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting			Urinalysis is required. Numerical readings must be recorded.				
Second reading (optional)							
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			☐ ☐
Monocular vision			☐ ☐
Referred to ophthalmologist or optometrist?			☐ ☐
Received documentation from ophthalmologist or optometrist?			☐ ☐

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			
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
_____	_____	_____	_____
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	☐	☐	8. Abdomen	☐	☐
2. Skin	☐	☐	9. Genito-urinary system including hernias	☐	☐
3. Eyes	☐	☐	10. Back/spine	☐	☐
4. Ears	☐	☐	11. Extremities/joints	☐	☐
5. Mouth/throat	☐	☐	12. Neurological system including reflexes	☐	☐
6. Cardiovascular	☐	☐	13. Gait	☐	☐
7. Lungs/chest	☐	☐	14. Vascular system	☐	☐

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): _____ /WORKRIGHT CLINIC 708-579-4900

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

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

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner (specify): _____

National Registry Number: _____

Medical 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): _____ /WORKRIGHT CLINIC 708-579-4900

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

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

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____