



U.S. Department of Transportation

Federal Motor Carrier

Safety Administration

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.

Medical Examiner's Certificate

(for Commercial Driver Medical 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 ☐ 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's Signature	Medical Examiner's Telephone Number	Date Certificate Signed
Medical Examiner's Name <i>(please print or type)</i>	☐ 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	Driver's License Number	Issuing State/Province
Driver's Address		
Street Address: _____	City: _____ State/Province: _____	Zip Code: _____
		CLP/CDL Applicant/Holder
		☐ Yes ☐ No

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