

# MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined \_\_\_\_\_ In accordance with 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:

- |  |  |
|--|--|
| <input type="checkbox"/> wearing corrective lenses               | <input type="checkbox"/> driving within an exempt intracity zone (49 CFR 391.62)         |
| <input type="checkbox"/> wearing hearing aid                     | <input type="checkbox"/> accompanied by a Skill Performance Evaluation Certificate (SPE) |
| <input type="checkbox"/> accompanied by a _____ waiver exemption | <input type="checkbox"/> Qualified by operation of 49 CFR 391.64                         |

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER

TELEPHONE

DATE

MEDICAL EXAMINER'S NAME (PRINT)

MD

DO

Chiropractor

Physician  
Assistant

Advanced  
Practice  
Nurse

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE

SIGNATURE OF DRIVER

DRIVER'S LICENSE NO.

STATE

ADDRESS OF DRIVER

MEDICAL CERTIFICATE EXPIRATION DATE