

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"/> wearing hearing aid
<input type="checkbox"/> accompanied by a _____ waiver exemption | <input type="checkbox"/> driving within an exempt intracity zone (49 CFR 391.62)
<input type="checkbox"/> accompanied by a Skill Performance Evaluation Certificate (SPE)
<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
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MEDICAL EXAMINER'S NAME (PRINT)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Practice Nurse
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MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE

SIGNATURE OF DRIVER	DRIVER'S LICENSE NO.	STATE
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ADDRESS OF DRIVER

MEDICAL CERTIFICATE EXPIRATION DATE
