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STATE OF NEW JERSEY

<<< **ATTENTION PHYSICIANS AND BUS DRIVERS** >>>

The Federal Motor Carrier Safety Administration (FMCSA) regulations C.F.R. 383.73(o) requires that New Jersey commercial driver license (CDL) holders must submit a valid (non-expired) Medical Examiner Certificate every two years including CDL drivers who maintain a passenger endorsement.

To avoid processing delays of your passenger endorsement application or suspension of your passenger endorsement, *all data fields on the Medical Examiner Certificate must be fully completed.*

Incomplete, expired or illegible medical examiner certificates will be rejected and may result in administrative action against your commercial driving privileges. Medical examinations performed on or after May 21, 2014 are to be completed by a federally certified medical examiner. To locate your nearest certified examiner, please go to [nrcme.fmcsa.gov](http://nrcme.fmcsa.gov).

**CHECKLIST**

- All Data Fields filled in and legible
- Signature of Driver
- Medical Examiner's Signature, License/Certificate No.
- National Registry No.
- Date of Exam (month/day/year)
- Medical Certification Expiration Date (month/day/year)

**MAIL TO:**

NJ Motor Vehicle Commission  
Driver Review Bus Application Unit  
PO Box 127  
Trenton, NJ 08666

For further assistance, contact the MVC Bus Application Unit by phone at (609) 292-7500 ext. 5039.

**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 1 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: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 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 **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
- Wearing hearing aid
- Accompanied by a \_\_\_\_\_ waiver/exemption
- Accompanied by a Skill Performance Evaluation (SPE) Certificate
- Driving within an exempt intracity zone ([49 CFR 391.62](#)) (Federal)
- Qualified by operation of [49 CFR 391.64](#) (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** *(please print or type)*

- MD
- DO
- Physician Assistant
- Chiropractor
- Advanced Practice Nurse
- Other Practitioner *(specify)* \_\_\_\_\_

**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**

**CLP/CDL Applicant/Holder**

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_  Yes  No