New Jersey
Motor Vehicle Commission

New Jersey Medical Examination Form

(Medical examination form to be completed by a licensed medical doctor or osteopathic physician. Submit only the Medical Doctor or Osteopathic Physician Evaluation page, located at the end of this form, to employer for drivers 70 years of age and older)

AUTHORITY: N.J.S.A. 39:3-10.1, N.J.S.A. 39:3-10.1a

PURPOSE: To record results of a driver's physical examination, to determine physical fitness to operate a school bus, and to promote driver health in accordance with the requirements in N.J.S.A. 39:3-10.1 and N.J.S.A. 39:3-10.1a. Providing this information is mandatory for school bus drivers 70 years of age and older.

INSTRUCTIONS: School bus drivers 70 years of age through 74 years of age: You must have this form satisfactorily completed annually. The Medical Doctor or Osteopathic Physician Evaluation page, located at the end of this form, must be provided to your employer.

School bus drivers 75 years of age and older: You must have this form satisfactorily completed every six (6) months. The Medical Doctor or Osteopathic Physician Evaluation page, located at the end of this form, must be provided to your employer.

This form must be completed by a licensed medical doctor or osteopathic physician.

This form is in addition to the Medical Examiner's Certificate required by 49 CFR 391.43 and shall not be submitted or used in place of that form. All school bus drivers must continue to submit the federally required Medical Examiner's Certificate. In addition, you must submit the Medical Doctor or Osteopathic Physician Evaluation page, located at the end of this form, to your employer. DO NOT SUBMIT THIS FORM OR THE MEDICAL DOCTOR OR OSTEOPATHIC PHYSICIAN EVALUATION TO THE NEW JERSEY MOTOR VEHICLE COMMISSION. The Medical Doctor or Osteopathic Physician Evaluation page must be provided to your employer and kept with your employment records for the term of your employment.

School Bus drivers who do not comply with the above requirements may have their school bus endorsement suspended as per N.J.S.A. 39:3-10.1.

ACKNOWLEDGMENT: ***I certify that all statements made by me are accurate and true. I understand that any misstatement of fact may subject me to administrative, civil and/or criminal penalties.***

Driver's Signature:_____ Date:_____

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):*_____ Gender: ○ M ○ F

CDL 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

*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.

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)*? ○ **Yes** ○ **No** ○ **Not Sure**
If "yes," please describe below:

Do you have or have you ever had:

	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures, epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
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**

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that any misstatement of fact may invalidate my NJ Medical Examination Form and subject me to administrative, civil and/or criminal penalties.

Driver's Signature: _____ Date: _____

Examination Form *(to be filled out by the licensed medical doctor or osteopathic physician)*

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).

TESTING

Pulse rate: _____ Pulse rhythm regular: ◯ Yes ◯ No

Height: _____ feet _____ inches
Weight: _____ pounds

Other testing if indicated:

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 New Jersey Medical Examination Form.

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?	◯	◯

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

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	Right Ear	Left Ear
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	1000 Hz	2000 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 licensed medical doctor or osteopathic physician 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:

Please complete the following licensed medical doctor or osteopathic physician evaluation section:

New Jersey
Motor Vehicle Commission

New Jersey Medical Examination Form
Medical Doctor or Osteopathic Physician Evaluation

I certify that I have examined:

Last Name: _____ First Name:_____ in accordance with the standards in 49 CFR 391.41: http://www.state.nj.us/mvc/pdf/business/NJDR-15.pdf and, with knowledge of the driving duties,

○ I find this person **does not** meet the standards in 49 CFR 391.41 (specify reason):

○ I find this person **does** meet the standards in 49 CFR 391.41 and, *if applicable*, only when (check all that apply):

□ Wearing corrective lenses

□ Wearing hearing aid

I have performed this evaluation for continuing physical fitness. The information I have provided regarding this physical examination, to the best of my knowledge, is true and complete. A complete New Jersey Medical Examination Form, DR-15, with any attachments embodies my findings completely and correctly, and is on file in my office.

_____
Medical Doctor or Osteopathic Physician's Signature

Name (*please print or type*): _____

Address: _____ City: _____ State: _____ Zip Code:_____

Telephone Number: _____ Date Form Signed: _____

_____ _____
State License or Certificate Number Issuing State

☐ MD ☐ DO Date of NJ Medical Examination: _____

_____ _____
Driver's Signature Issuing State

_____
Driver License Number

Driver's Address: _____ CDL Holder/School Bus (S) Endorsement

City: _____ State: _____ Zip Code: _____ ○ Yes ○ No

This Medical Doctor or Osteopathic Physician Evaluation page must be given to your employer and kept with your employment records for the term of your employment.

Employers of school bus drivers who do not maintain this evaluation are subject to the penalties prescribed in N.J.A.C. 13:20-30.17.

**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. **
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