## 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:

- ☐ wearing corrective lenses
- ☐ wearing hearing aid
- ☐ accompanied by a _____ waiver/exemption
- ☐ driving within an exempt intracity zone (49 CFR 391.62)
- ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ 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