Form MCSA-5876 OMB No. 2126-0006 Expiration Date: 9/30/2019

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 ◯ Physician Assistant ◯ Advanced Practice Nurse
◯ DO ◯ Chiropractor ◯ 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

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

CLP/CDL Applicant/Holder

◉ Yes ◯ No

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