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

Public Burden Statement

2

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 burden terponse, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information of information are mandatory. Send comments regarding 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 o	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 ☐ Accompanied by a waiver/exem		•	
☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Cert		_ ,	
☐ Grandfathered fro		Grandfathered from State requirem	ents (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 Signature		Medical Examiner's Telephone Number	Date Certificate Signed
Medical Examiner's Name (please print or type)			 nced Practice Nurse
		○ DO	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	o Code: O Yes O No

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