

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 25 minutes 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: Medical Programs Division, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

(or sticker)

SECTION 1. 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): _____ CLP/CDL Applicant/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

*CLP/CDL Applicant/Holder: See instructions for definitions.

**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.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. Yes No Not Sure

Empty box for listing and explaining any surgery.

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below. Yes No Not Sure

Empty box for describing any current medications.

(Attach additional sheets if necessary)

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.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

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

Other health condition(s) not described above: Yes No Not Sure

Empty box for other health conditions.

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: Yes No Not Sure

Empty box for comments on health conditions.

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

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).

Empty box for driver health history review.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: Yes No Height: ___ feet ___ inches Weight: ___ pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting			Urinalysis is required. Numerical readings must be recorded.				
Second reading (optional)							

Other testing if indicated

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

<p>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 Medical Examiner's Certificate.</p> <p>Acuity</p> <table border="0"> <tr> <td></td> <td>Uncorrected</td> <td>Corrected</td> <td>Horizontal Field of Vision</td> </tr> <tr> <td>Right Eye:</td> <td>20/____</td> <td>20/____</td> <td>Right Eye: ____ degrees</td> </tr> <tr> <td>Left Eye:</td> <td>20/____</td> <td>20/____</td> <td>Left Eye: ____ degrees</td> </tr> <tr> <td>Both Eyes:</td> <td>20/____</td> <td>20/____</td> <td></td> </tr> </table> <p>Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors <input type="radio"/> Yes <input type="radio"/> No</p> <p>Monocular vision <input type="radio"/> Yes <input type="radio"/> No</p> <p>Referred to ophthalmologist or optometrist? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Received documentation from ophthalmologist or optometrist? <input type="radio"/> Yes <input type="radio"/> No</p>		Uncorrected	Corrected	Horizontal Field of Vision	Right Eye:	20/____	20/____	Right Eye: ____ degrees	Left Eye:	20/____	20/____	Left Eye: ____ degrees	Both Eyes:	20/____	20/____		<p>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).</p> <p>Check if hearing aid used for test: <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Neither</p> <p>Whisper Test Results Right Ear Left Ear</p> <p>Record distance (in feet) from driver at which a forced whispered voice can first be heard _____</p> <p>OR</p> <p>Audiometric Test Results</p> <table border="0"> <tr> <td>Right Ear:</td> <td></td> <td>Left Ear:</td> <td></td> </tr> <tr> <td>500 Hz</td> <td>1000 Hz</td> <td>2000 Hz</td> <td>500 Hz</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <p>Average (right): _____ Average (left): _____</p>	Right Ear:		Left Ear:		500 Hz	1000 Hz	2000 Hz	500 Hz	_____	_____	_____	_____
	Uncorrected	Corrected	Horizontal Field of Vision																										
Right Eye:	20/____	20/____	Right Eye: ____ degrees																										
Left Eye:	20/____	20/____	Left Eye: ____ degrees																										
Both Eyes:	20/____	20/____																											
Right Ear:		Left Ear:																											
500 Hz	1000 Hz	2000 Hz	500 Hz																										
_____	_____	_____	_____																										

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 Medical Examiner 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	<input type="radio"/>	<input type="radio"/>	8. Abdomen	<input type="radio"/>	<input type="radio"/>
2. Skin	<input type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input type="radio"/>	<input type="radio"/>
3. Eyes	<input type="radio"/>	<input type="radio"/>	10. Back/spine	<input type="radio"/>	<input type="radio"/>
4. Ears	<input type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input type="radio"/>	<input type="radio"/>	13. Gait	<input type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input type="radio"/>	<input type="radio"/>	14. Vascular system	<input type="radio"/>	<input type="radio"/>

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.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- Does not meet standards (specify reason): _____
- Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- Meets standards, but periodic monitoring required (specify reason): _____
 Driver qualified for: 3 months 6 months 1 year other (specify): _____
 Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____
 Accompanied by a Skill Performance Evaluation (SPE) Certificate
 Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- Determination pending (specify reason): _____
 Return to medical exam office for follow-up on (must be 45 days or less): _____
 Medical Examination Report amended (specify reason): _____
 (if amended) Medical Examiner's Signature: _____ Date: _____
- Incomplete examination (specify reason): _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): Stacey Rhodes

Medical Examiner's Address: 1405 S. 8th Ave. Suite 103 City: Sterling State: CO Zip Code: 80751

Medical Examiner's Telephone Number: (970) 740-3304 Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: 1749 Issuing State: CO

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: 5913722075

Medical Examiner's Certificate Expiration Date:

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with 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):

- Does not meet standards in 49 CFR 391.41 with any applicable State variances (specify reason): _____
- Meets standards in 49 CFR 391.41 with any applicable State variances
- Meets standards, but periodic monitoring required (specify reason): _____
 Driver qualified for: 3 months 6 months 1 year other (specify): _____
- Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____
- Accompanied by a Skill Performance Evaluation (SPE) Certificate Grandfathered from State requirements (State)

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): Stacey Rhodes

Medical Examiner's Address: 1405 S 8th Ave Suite 103 City: Sterling State: CO Zip Code: 80751

Medical Examiner's Telephone Number: (970) 740-3304 Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: 1749 Issuing State: CO

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: 5913722075

Medical Examiner's Certificate Expiration Date:

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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 391.41-391.42) 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/exemption Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
- Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate Grandfathered from State requirements (State)

Medical Examiner's Certificate Expiration Date

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 Name (please print or type)

Stacey Rhodes

Medical Examiner's Telephone Number

(970) 740-3304

Date Certificate Signed

- MD Physician Assistant Advanced Practice Nurse
- DO Chiropractor Other Practitioner (specify) _____

Medical Examiner's State License, Certificate, or Registration Number

1749

National Registry Number

5913722075

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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Northeast Colorado Family Medicine
1405 S 8th Ave Ste 103 Sterling, Colorado 80751
P: (970) 522-3304
F: (970) 522-4615

Consent to Release Information for Department of Transportation Physical

I, _____ authorize Northeast Colorado Family Medicine Associates, P.C., (Charles A. Gerk, MD; Rachelle Maker, FNPC; Karlie Urbach, MD; Stacey Rhodes, PA-C; Bonnie Brownell, FNPC) to release my personal health information to my employer, the State of Colorado and the Federal Motor Carriers Safety Administration as it relates to my certification to apply and retain a commercial driver license.

Patient Signature

Date

Printed Name

Name of Employer