

## 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  driving within an exempt intracity zone (49 CFR 391.62)  
 wearing hearing aid  accompanied by a Skill Performance Evaluation Certificate (SPE)  
 accompanied by a \_\_\_\_\_ waiver/exemption  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)		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor	
		<input type="checkbox"/> Physician Assistant <input type="checkbox"/> 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			