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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:	Gender: OM OF
E-mail (optional):		CLP/CDL Applican	t/Holder*: O Yes O!	No
		Driver ID Verified B	By**:	
Has your USDOT/FMCSA medical certifi	cate ever been denied or issued for le			
*CLP/CDL Applicant/Holder: See instructions for definitions.		**Driver ID Verified By: Record what typ	e of photo ID was used to verify the identity	y of the driver, e.g., CDL, driver's license, passport.
DRIVER HEALTH HISTORY				
Have you ever had surgery? If "yes," ple	ase list and explain below.			○ Yes ○ No ○ Not Sure
				33
				1
Are you currently taking medication If "yes," please describe below.	s (prescription, over-the-counter, herbal	remedies, diet supplements,	)?	○ Yes ○ No○ Not Sure

(Attach additional sheets if necessary)

<sup>\*\*</sup>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)									
D bass or base year area had	Vec	No	Not		Yes	No	Not   Sure		
Do you have or have you ever had:  1. Head/brain injuries or illnesses (e.g., concussion)	$\bigcirc$	$\circ$		16. Dizziness, headaches, numbness, tingling, or memory	0	0			
2. Seizures, epilepsy	$\tilde{O}$	0	Ö	loss		_	_		
3. Eye problems (except glasses or contacts)	0	Ö	Ō	17. Unexplained weight loss	0	0	0		
4. Ear and/or hearing problems	Õ	Ö	Ö	18. Stroke, mini-stroke (TIA), paralysis, or weakness	0	$\circ$	0		
5. Heart disease, heart attack, bypass, or other heart	Õ	Ō	Ō	19. Missing or limited use of arm, hand, finger, leg, foot, toe	0	0	0		
problems				20. Neck or back problems	0	$\circ$	0		
6. Pacemaker, stents, implantable devices, or other heart	$\circ$	0	0	21. Bone, muscle, joint, or nerve problems	0	$\circ$	0		
procedures		$\bigcirc$	$\circ$	22. Blood clots or bleeding problems	0		0		
7. High blood pressure	0	0	0	23. Cancer	0	0	0 0		
8. High cholesterol		0	0	24. Chronic (long-term) infection or other chronic diseases	0	0	0		
<ol><li>Chronic (long-term) cough, shortness of breath, or other breathing problems</li></ol>	0		0	<ol> <li>Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring</li> </ol>	-	_	_		
10. Lung disease (e.g., asthma)	0	0	0	26. Have you ever had a sleep test (e.g., sleep apnea)?	0	0	0		
11. Kidney problems, kidney stones, or pain/problems with	0	0	$\circ$	27. Have you ever spent a night in the hospital?	0	0	0		
urination	$\overline{}$	0	$\cap$	28. Have you ever had a broken bone?	0	0	0		
12. Stomach, liver, or digestive problems		0	0	29. Have you ever used or do you now use tobacco?	0	0	0		
13. Diabetes or blood sugar problems		$\hat{}$	$\circ$	30. Do you currently drink alcohol?	0	0	0		
Insulin used  14. Anxiety, depression, nervousness, other mental health	0	0	0	31. Have you used an illegal substance within the past two years?	O	O	0		
problems 15. Fainting or passing out	0	0	0	32. Have you ever failed a drug test or been dependent on an illegal substance?	0	0	0		
The state of the state of 1 222 lf completes		nent :		er on those health conditions below.	No C	No	t Sure		
Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below.  Yes No Not Sure  (Attach additional sheets if necessary)									
CMV DRIVER'S SIGNATURE  I certify that the above information is accurate and complete	e. l un	ders	and t	hat inaccurate, false or missing information may invalidate the	exam	inati	ion		
and my Medical Examiner's Certificate, that submission of fr of fraudulent or intentionally false information may subject	audul me to	ent c civil	or inte or cri	ntionally talse information is a violation of 49 CFR 380.35, and the minal penalties under 49 CFR 390.37 and 49 CFR 386 Appendic	., , , , , , , , ,	20:11	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Driver's Signature:				Date:					
SECTION 2. Examination Report (to be tilled out by the med.	ical ex	ramin	er)						
DRIVER HEALTH HISTORY REVIEW						, eft			
Review and discuss pertinent driver answers and any available or driver's safe operation of a commercial motor vehicle (CMV).	nedicai	l reco	rds. Co	mment on the driver's responses to the "health history" questions the	и тау	· arre	ci ine		
					,				
(Attach additional sheets if necessary									