

CDL WAIVER COVER SHEET

ATTENTION: THIS PAGE MUST BE COMPLETED AND INCLUDED WITH ANY WAIVER DOCUMENTS THAT ARE SUBMITTED

NAME _____

DATE OF BIRTH _____

DRIVERS LICENSE NO. _____

CIRCLE TYPE OF WAIVER: **DIABETIC** **VISION** **LIMB**

MAIL OR FAX INFORMATION:

MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER
RALEIGH, NC 27697
FAX NO: (919) 733-9569

IMPORTANT!!!

PLEASE INCLUDE THIS PAGE WITH YOUR COMPLETED FORMS WHEN FAXING OR MAILING WAIVER DOCUMENTATION TO DMV.

North Carolina Division of Motor Vehicles

CDL Waiver Program

Commercial Driver's License Limb Waiver Application

Name of the Driver (Printed)	Driver's License Number	Date of Birth	Date	
Address	City	State	Zip Code	Phone Number

I, the undersigned driver, am applying for a waiver from the qualifications of 49 CFR Sec. 391.41(b)(1) or (b)(2)(i) or (b)(ii), noted below.

(b) A person is physically qualified to drive a commercial motor vehicle if that person—

- 1) *Has no loss of a foot, a leg, a hand, or an arm, or has been granted a waiver pursuant to Sec.391.49 (limb waiver provision);*
- 2) *Has no impairment of :*
 - i) *A hand of finger which interferes with prehension or power grasping; or power grasping; or*
 - ii) *An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or any other significant limb defect or limitation which interferes with the ability to perform normal tasks operating a commercial motor vehicle; or has been granted a waiver pursuant to Sec. 391.49.*

My limb impairment or loss is as follows: _____

I, the undersigned, hereby authorize Dr. _____ to give any examination deemed necessary to assess my limb deformity, impairment or amputation and its impact on the safe operation of a commercial motor vehicle. I also authorize this physician and any other physicians, health care providers, hospitals and clinics involved in my care to release to the Division of Motor Vehicles or its representatives any information concerning my condition. I do hereby release, waive, and relinquish all claims against the Division of Motor Vehicles, its agents and employees, for any cause whatsoever arising out of this release of said medical information.

Date _____ Signature of the Applicant _____

Instructions to the Driver: This page contains your instructions for completing the waiver application. Complete all of the steps below before mailing it to DMV. An incomplete application will not be processed. Any missing or incomplete information will therefore delay processing of your application until all parts of the application are fully completed and received by DMV.

- 1) Provide a copy of a valid DOT physical certifying that you are otherwise physically qualified to drive a commercial motor vehicle.
- 2) Sign the above consent for examination and release of medical information.
- 3) Have an examination by an orthopedics or rehabilitation medicine physician to evaluate your limb impairment and its affect on the safe operation of commercial motor vehicles.
- 4) You or your employer must complete the Vehicle and Driving Conditions Report enclosed with these forms. This report should reflect any circumstances in which you expect to be driving, and include information about all types of vehicles that you may be driving. If you are not currently employed, please indicate on the form.
- 5) At the time of and during your examination you must do the following:
 - a) Describe to your doctor any prostheses, assistive devices, restrictions, vehicle modifications, or compensatory strategies you use for driving.
 - b) Review the Vehicle and Driving Conditions Report with your physician.
 - c) After your examination, be sure your doctor completes the Limb Medical Report.

North Carolina Division of Motor Vehicles
 CDL Limb Waiver Program
PHYSICIAN'S REPORT

Name of the Driver _____	Date of Birth _____	Driver's License Number _____
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Description of limb amputation deformity or impairment.

Medical condition that resulted in the above limb problem.

Functional limitations caused by the limb problem (without prostheses, vehicle modifications, etc.) and the adverse affect on the operation of a commercial vehicle.

Prostheses, assistive devices, restrictions, vehicle modifications, or compensatory strategies currently being used by the driver.

How the above aids compensate for the adverse impact of the impairment and whether the impairment is fully compensated.

Any recommendations for additional aids necessary to enable the driver to safely operate a commercial vehicle. (For example, power steering or brakes, automatic transmission, wheel knob, grasping hook, electric signals, or an altered or different prosthesis.

Stability or progression of the impairment expected over the next two years.

Other conditions of which you are aware, that might contribute to increased driving risk.

1.	I am board certified or board eligible in orthopedics or rehabilitation medicine. (Circle the appropriate status and specialty.)
2.	I have reviewed the Vehicle and Driving Conditions Report, and understand the type of vehicle driving conditions, and non-driving job tasks the driver will be required to perform.
3.	The information available to me at the time of this exam is sufficient to determine the physical ability of the driver to operate a commercial vehicle with the current impairment with appropriate prostheses, vehicle modifications, or restrictions.

Printed Name and License Number _____	Signature _____	Date _____
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Address _____	City _____	State _____	Zip Code _____	Area Code and Number _____
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North Carolina Division of Motor Vehicles
Commercial Drivers License Waiver Program

Vehicle and Driving Conditions Report

Status of the driver	Applied/accepted to truck driving school	Currently enrolled student in truck driving school	
	Unemployed	Hired pending exemption	Currently employed
Employer _____ Address _____ City _____ State _____ Zip Code _____ Area Code and Number _____			
Name of the Driver _____ Date of Birth _____ License Number _____			

FORM COMPLETED BY

Printed Name _____ Signature _____ Date Completed _____

If the driver operates more than one type of vehicle, check all that apply.

TRUCK	Gross vehicular Weight		Drive Train Information	Number of axles					
				Number of manual forward speeds					
				Number of auxiliary forward speeds					
				Number of rear axle transmission forward speeds					
				Transmission type:		Manual		Automatic	
				Braking	Manual		Powered		Airbrakes
Steering	Manual		Powered						
For passenger vehicles, seating capacity:									
TRAILER(S)	Gross Vehicular Weight		Number towed at one time	1	2	3	Van	Flatbed	
							Bin	Tanker	
							Pole	Other	

MODIFICATIONS MADE FOR THE DRIVER (if applicable)	(include relevant photographs)

TIME AND DISTANCE		Round trip distance	Hours per 7 day week	Hours per 24 hour day	Daylight hours per week	Nighttime hours per week
	Average					
	Maximum					

TRAFFIC AND ROAD CONDITIONS	Secondary roads		Rural	
	Interstate highway		Urban	

TRANSPORTED CARGO	List

NON-DRIVING ACTIVITIES	Hitching and unhitching		Loading and unloading	
	Covering or tying down		Filling or emptying tankers	
	Other (describe)			

TYPE OF DRIVER OPERATION	Relay
	Single driver
	Sleeper team
	Owner-operator
	Non-driving individuals accompanying the driver

Number of years of driving experience:	Total years driving experience
	Number driving the vehicle described above

**North Carolina Department of Motor Vehicles Vision Specialist
Form DL77**

I, _____, hereby authorize Dr. _____ to provide my examination information for the purposes of determining my visual fitness to operate a motor vehicle. I understand this authorizes the Division to review my case.

Applicant Signature _____ License/Customer number _____

Parent/Guardian if Minor _____ Telephone number _____

To be completed by licensed Ophthalmologist or Optometrist

1. What is the vision diagnosis? _____

2. Which eye(s) are affected: both right left

3. Is the condition: permanent stable progressive improving

(check all that apply)

4. Best corrected Visual Acuity:
(Using conventional lenses)

Both 20/	Right 20/	Left 20/
Both 20/	Right 20/	Left 20/

5. Uncorrected Visual Acuity:

6. New lenses prescribed? Yes No

7. Are corrective lenses recommended for driving? Yes No

8. What is the horizontal field of view in each eye without field expanders? (Specify in degrees)

Right Eye: _____° nasal _____° temporal	Left Eye: _____° nasal _____° temporal
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Test used: Confrontation Goldmann Automated

9. Are there other visual issues that might affect driving?

No Depth perception Diplopia Contrast sensitivity Glare sensitivity Color vision impairment

10. Is a bioptic telescope used for driving? Yes No (If no, skip to # 16)

11. If yes, how long has the bioptic been used? New Duration: _____ months/years (circle)

12. If yes, for which eyes(s)? Both Right Left

13. Visual acuity through bioptic telescope: Both: 20/ _____ Right: 20/ _____ Left: 20/ _____

14. Has the individual driven previously without a bioptic telescope? Yes No

15. Has the individual completed certified training in the use of a bioptic for driving? Yes No

16. Are there any other concerns regarding this individual's fitness to safely operate a motor vehicle?

No Cognitive Physical Psychological Other: _____

17. What driving restriction(s), if any, do you recommend based upon your examination?

None 45mph limit/No interstate Daylight only Local driving only: _____ miles from home **Should not drive**

18. Other recommendations for highway safety purposes (check all that apply):

DMV follow-up: 6 months every: circle: (1) (2) (3) year(s)

On road evaluation by DMV (or approved examiner)

Other: _____

Vision Examiner:

Name _____ Degree _____ License # _____

Address _____

Phone _____ Fax _____

Signature _____ Date _____

Instructions: Fax this completed and signed form to the NC DMV Medical Review Section at (919) 733-9569

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: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



Department of Transportation
 Motor Carrier
 Administration

Medical Examination Report Form

(for Commercial Driver Medical Certification)

PRIVACY ACT STATEMENT: *This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.*

AUTHORITY: Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

PURPOSE: To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State.

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of the examination. Medical examiners must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local representative, within 48 hours after the request is made [49 CFR 391.43(i)].

ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies if necessary. Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132) "Uses" (available at <http://www.dot.gov/privacy/privacyactnotices>).

ACKNOWLEDGMENT: *I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned.*

Driver's Signature: _____ Date: _____

MEDICAL RECORD #

(or sticker)

49 CFR 391.41. Each original

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: M F

E-mail (optional): _____ CLP/CDL Applicant/Holder*: Yes No

Driver ID Verified By**: _____
 Yes No Not Sure

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years?

*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

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

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

Last _____ Name: _____

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"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<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"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<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"/>
5. Heart disease, heart attack, bypass, or other heart 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"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. High blood pressure	<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"/>
8. High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<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"/>	23. Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<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"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<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"/>
12. Stomach, liver, or digestive problems	<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"/>
13. Diabetes or blood sugar problems/Insulin used	<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"/>
14. Anxiety, depression, nervousness, other mental health problems	<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"/>
15. Fainting or passing out	<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"/>
				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

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

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: _____

Last _____	Name: _____
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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).

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Last _____ Name: _____

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

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. <i>Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.</i>				
Second reading (optional)	_____	_____					
Other testing if indicated	_____						

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.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right	_____	_____	_____ degrees
Left	_____	_____	_____ degrees
Both	_____	_____	_____ degrees

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors Yes No

Monocular vision Yes No

Referred to ophthalmologist or optometrist? Yes No

Received documentation from ophthalmologist or optometrist? Yes No

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).

Check if hearing aid used for test: Right Ear Left Ear Neither

Whisper Test Results
Record distance (in feet) from driver at which a forced whispered voice can first be heard

	Right Ear	Left Ear
500 Hz	_____	_____
1000 Hz	_____	_____
2000 Hz	_____	_____
Average (right):	_____	Average (left): _____

PHYSICAL EXAMINATION

Last _____ Name: _____

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.

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

Last _____ Name: _____

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 Qualified by operation of 49 CFR 391.64 (Federal)
- 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): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

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

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

49 CFR 391.41-391.49
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): _____

Last _____	Name: _____
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Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

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

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (*specify*): _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

Instructions for Completing the Medical Examination Report Form (MCSA-5875)

I. Step-By-Step Instructions

Driver:

Privacy Act Statement - Please read, sign and date the Statement acknowledging that you understand the provisions of the Privacy Act of 1974 as written.

Section 1: Driver information · Personal Information: Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, gender, driver's license number and issuing state.

- **CLP/CDL Applicant/Holder:** Check "yes" if you are a commercial learner's permit (CLP) or commercial driver's license (CDL) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (CMV). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (GVWR) or gross vehicle weight (GVW) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
- **Driver ID Verified By:** The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
- **Question: Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box "yes" or "no" and if you aren't sure check the "not sure" box.

Driver Health History:

- **Have you ever had surgery:** Please check "yes" if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
- **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check "yes" if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
- **#1-32:** Please complete this section by checking the "yes" box to indicate that you have, or have ever had, the health condition listed or the "No" box if you have not. Check the "not sure" box if you are unsure.
- **Other Health Conditions not described above:** If you have, or have had, any other health conditions not listed in the section above, check "Yes" and in the box provided and list those condition(s).
- **Any yes answers to questions #1-32 above:** If you have answered "yes" to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered "yes" to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked "yes" to

question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.

- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

Medical Examiner:

Section 2: Examination Report

- **Driver Health History Review:** Review answers provided by the driver in the driver health history section and discuss any “yes” and “not sure” responses. In addition, be sure to compare the medication list to the health history responses ensuring that the medication list matches the medical conditions noted. Explore with the driver any answers that seem unclear. Record any information that the driver omitted. As the Medical Examiner conducting the driver's physical examination you are required to complete the entire medical examination even if you detect a medical condition that you consider disqualifying, such as deafness. Medical Examiners are expected to determine the driver's physical qualification for operating a commercial vehicle safely. Thus, if you find a disqualifying condition for which a driver may receive a Federal Motor Car-rier Safety Administration medical exemption, please record that on the driver's Medical Examiner's Cer-tificate, Form MCSA-5876, as well as on the Medical Examination Report Form, MCSA-5875.
- **Testing:**
 - **Pulse rate and rhythm, height, and weight:** record these as indicated on the form.
 - **Blood Pressure:** record the blood pressure (systolic and diastolic) of the driver being examined. A second reading is optional and should be recorded if found to be necessary.
 - **Urinalysis:** record the numerical readings for the specific gravity, protein, blood and sugar.
 - **Vision:** The current vision standard is provided on the form. When other than the Snellen chart is used, give test results in Snellen-comparable values. When recording distance vision, use 20 feet as normal. Record the vision acuity results and indicate if the driver can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors; has monocular vision; has been referred to an ophthalmologist or optometrist; and if documentation has been received from an ophthalmologist or optometrist.
 - **Hearing:** The current hearing standard is provided on the form. Hearing can be tested using either a whisper test or audiometric test. Record the test results in the corresponding section for the test used.
- **Physical Examination:** Check the body systems for abnormalities and indicate normal or abnormal for each body system listed. Discuss any abnormal answers in detail in the space provided and indicate whether it would affect the driver's ability to safely operate a commercial motor vehicle.

In this next section, you will be completing either the Federal or State determination, not both.

- **Medical Examiner Determination (Federal):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49). Complete the medical examiner determination section completely. When determining a driver's physical qualification, please note that English language proficiency (49 CFR part 391.11; General qualifications of drivers) is not factored into that determination.

- **Does not meet standards:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41.
- **Meets standards in 49 CFR 391.41; qualifies for 2-year certification:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.
- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified and if selecting other, specify the time frame.
- **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, driving within an exempt intracity zone, etc.).
- **Determination pending:** Select this option when more information is needed to make a qualification decision and specify a date, on or before the 45 day expiration date, for the driver to return to the medical exam office for follow-up. This will allow for a delay of the qualification decision for as many as 45 days. If the disposition of the pending examination is not updated via the National Registry on or before the 45 day expiration date, FMCSA will notify the examining medical examiner and the driver in writing that the examination is no longer valid and that the driver is required to be re-examined.
- **MER amended:** A Medical Examination Report Form (MER), MCSA-5875, may only be amended while in determination pending status for situations where new information (e.g., test results, etc.) has been received or there has been a change in the driver's medical status since the initial examination, but prior to a final qualification determination. Select this option when a Medical Examination Report Form, MCSA-5875, is being amended; provide the reason for the amendment, sign and date. In addition, initial and date any changes made on the Medical Examination Report Form, MCSA-5875. A Medical Examination Report Form, MCSA-5875, cannot be amended after an examination has been in determination pending status for more than 45 days or after a final qualification determination has been made. The driver is required to obtain a new physical examination and a new Medical Examination Report Form, MCSA-5875, should be completed.
- **Incomplete examination:** Select this when the physical examination is not completed for any reason (e.g., driver decides they do not want to continue with the examination and leaves) other than situations outlined under determination pending.
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, Medical Examiner's Certificate expiration date, signature and date.
- **Medical Examiner Determination (State):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations). Complete the medical examiner determination section completely.
- **Does not meet standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41 with any applicable State variances.

- **Meets standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.
 - **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified and if selecting other, specify the time frame.
 - **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, etc.).
 - **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, Medical Examiner's Certificate expiration date, signature and date.
- II. If updating an existing exam, you must resubmit the new exam results, via the Medical Examination Results Form, MCSA-5850, to the National Registry, and the most recent dated exam will take precedence.**
- III. To obtain additional information regarding this form go to the Medical Program's page on the Federal Motor Carrier Safety Administration's website at <http://www.fmcsa.dot.gov/regulations/medical>.**