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: **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	Area Code and 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

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

Address	City	State	Zip Code	Area Code and Number

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)

		Round trip distance	Hours per 7 day week	Hours per 24 hour day	Daylight hours per week	Nighttime hours per week
TIME AND DISTANCE	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/
5. Uncorrected Visual Acuity:	Both 20/	Right 20/	Left 20/

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

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 <u>without</u> 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:_____

<u>Vision Examiner:</u>

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

Division of Motor Vehicles, Medical Review Unit, 3112 Mail Service Center, Raleigh NC 27697-3112 ver 1/26/17

OMB No.: 2126-0006 Expiration Date: 03/31/2025

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**

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

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

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

(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).

(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
Sitting		
Second reading *(optional)*		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

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

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 Eye:	20/____	20/____	Right Eye: ____ degrees
Left Eye:	20/____	20/____	Left Eye: ____ degrees
Both Eyes:	20/____	20/____	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

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	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	_____	_____

OR

Audiometric Test Results

Right Ear:			Left Ear:		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
_____	_____	_____	_____	_____	_____

Average (right): _____ Average (left): _____

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	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Genito-urinary system including hernias	○	○
3. Eyes	○	○	10. Back/spine	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Neurological system including reflexes	○	○
6. Cardiovascular	○	○	13. Gait	○	○
7. Lungs/chest	○	○	14. Vascular system	○	○

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 ☐ 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: _____

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)*: _____

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:

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, 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.
  - **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 Carrier Safety Administration medical exemption, please record that on the driver's Medical Examiner's Certificate, 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 for, 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, signature and date.

- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

- **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 for, 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, signature and date.
- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

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.

Form MCSA-5876

OMB No.: 2126-0006 Expiration Date: 03/31/2025

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 391.41-391.49) 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/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*

☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Grandfathered from State requirements *(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 Certificate Expiration Date

Medical Examiner's Signature _____

Medical Examiner's Telephone Number _____

Date Certificate Signed _____

Medical Examiner's Name *(please print or type)* _____

○ MD ○ Physician Assistant ○ Advanced Practice Nurse
○ DO ○ Chiropractor ○ Other 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

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

CLP/CDL Applicant/Holder ○ Yes ○ No

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.

Rev 3/29/22