

**MEDICAL EXAMINER'S CERTIFICATE**

I certify that I have examined \_\_\_\_\_ in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 393.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- wearing corrective lenses
- wearing hearing aid
- accompanied by a \_\_\_\_\_ waiver/exemption
- driving within an exempt intracity zone (49 CFR 391.62)
- accompanied by a Skill Performance Evaluation Certificate (SPE)
- 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		

**MOTOR CARRIER COPY**

**SEPARATE MOTOR CARRIER COPY BEFORE REMOVING LINER FROM LAMINATE**