Public Burden Statement

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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 st	ticker)

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 Applicant/Holder*: O Yes O No

Driver ID Verified By**: ____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? O Yes O No O 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
	۸
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.**

New Note		Name: _				DOB: Exam Date:			
No you have or have you ever had: 1. Head/drain injuries or illnesses (e.g., concussion) 2. Sefezures, epilepispy 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 problems 7. High blood pressure 8. High cholesterol 9. Chronic (long-term) infection or other chronic diseases (e.g., conturn) and the problems 9. Chronic (long-term) infection or other chronic diseases (e.g., conturn) and the problems (except glasses) and the problems (except glasses) and the problems (except glasses) (e.g., conturn) and the problems (except glasses) (e.g., conturn) and the problems	DRIVER HEALTH HISTORY (continued)			9" (1 1 X					
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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)

Form MCSA-5875									OMB No. 2126-0	0006 Expiration	Date: 11/30/202
Last Name:			First Name:			D	ОВ:		Exam [Date:	
TESTING											
Pulse rate:	Pulse rhyth	m regular: C	Yes O No			Height:	feetinch	es Weight:	pounds		
Blood Pressure	Systolic		Diastolic			Urinalysis		Sp. Gr.	Protein	Blood	Sugar
Sitting							s required.				
Second reading (optional)						Numerical must be re					
Other testing if indic	ated							in the urine may medical probler	y be an indicati m.	on for further t	esting to
Vision Standard is at least 20/ least 70° field of vision i rective lenses should be	n horizontal me noted on the M	ridian measure edical Examine	ed in each eye. Th er's Certificate.	e use of co	At or-	hearing loss	of less than c	or equal to 40 dE	oice at not less 3, in better ear (with or withou	t hearing aid).
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Left Eye:	20/	20/	Left Eye:	_ degree	:S	whispered	voice can fii	st be heard			
Both Eyes:	20/	20/		Yes I	No	OR					
Applicant can recogn signals and devices s				0 (_	Audiomet Right Ear	ic Test Res	ults	Left Ear		
Monocular vision				0 (0	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
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Received documenta	ition from opht	:halmologist (or optometrist?	0 (0	Average (ri	ght):	3 6	Average (le	ft):	
PHYSICAL EXAMINA											
The presence of a cer is readily amenable to Also, the driver shoul result in a more serio	o treatment. Ev d be advised to us illness that r	en if a condit take the ned night affect o	ion does not di cessary steps to	squalify a	driv	ver, the Med	lical Examin	er may consid	der deferring t	he driver tem	porarily.
Check the body syste	ems for abnorm	alities.	1000	30. ±0		Store in the Visible Store				200 HDG .	
Body System				Abnorm	nal	Body Syst 8. Abdom					Abnormal
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3. Eyes			0	0		10. Back/S		cin including	Terrings	0	0
4. Ears			0	0		11. Extrem				0	0
5. Mouth/throat			0	0				m including re	eflexes	Ö	0
6. Cardiovascular			Ö	Ö		13. Gait	<i>₹</i> / (6)	3		Ö	Ö
7. Lungs/chest			0	0		14. Vascula	ır system			0	0
Discuss any abnormal Enter applicable item i	l answers in deta number before e	il in the space ach comment	below and indica	ate whethe	er it v	would affect	the driver's al	bility to operate	a CMV.		
									(Attach add	itional sheets i	fnecessani

OMB No. 2126-0006 Expiration Date: 11/30/2021 Form MCSA-5875 First Name: DOB: Exam Date: Last Name: 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): O 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): City: ______ State: ____ Zip Code: ____ Medical Examiner's Address: Date Certificate Signed: Medical Examiner's Telephone Number: Issuing State: Medical Examiner's State License, Certificate, or Registration Number: MD DO Physician Assistant Chiropractor Advanced Practice Nurse Other Practitioner (specify):

National Registry Number:

Medical Examiner's Certificate Expiration Date:

Form MCSA-5875 OMB No. 2126-0006 Expiration Date: 11/30/2021 DOB: Last Name: First Name: 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): Opes 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): _____ City: ______ State: ____ Zip Code: ____ Medical Examiner's Address: 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):

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