

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____ Exam Date: _____

Please complete only one of the Medical Examiner Determination sections below:**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: _____
- 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
- Driving within an exempt intracity zone (see 49 CFR 391.62)
- 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 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 Signature: _____ Medical Examiner Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Date: _____

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

 MD DO Physician Assistant Chiropractor Advanced Practice Nurse Other Practitioner

National Registry Number: _____

Medical Examiner's Certificate Expiration 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: _____
- 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

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 Signature: _____ Medical Examiner Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Date: _____

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

 MD DO Physician Assistant Chiropractor Advanced Practice Nurse Other Practitioner

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____