

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):*

- 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: \_\_\_\_\_