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: ___________________________