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 (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): ________________________________

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: ________