

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Medical Programs Division, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)**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: _____

E-Mail (optional): _____ CLP/CDL Applicant/Holder*: Yes No

Driver ID Verified By**: _____

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

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? Yes No Not Sure
If "yes," please describe below.

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.

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

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure	Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses (e.g., concussion)				16. Dizziness, headaches, numbness, tingling, or memory loss			
2. Seizures/epilepsy				17. Unexplained weight loss			
3. Eye problems (except glasses or contacts)				18. Stroke, mini-stroke (TIA), paralysis, or weakness			
4. Ear and/or hearing problems				19. Missing or limited use of arm, hand, finger, leg, foot, toe			
5. Heart disease, heart attack, bypass, or other heart problems				20. Neck or back problems			
6. Pacemaker, stents, implantable devices, or other heart procedures				21. Bone, muscle, joint, or nerve problems			
7. High blood pressure				22. Blood clots or bleeding problems			
8. High cholesterol				23. Cancer			
9. Chronic (long-term) cough, shortness of breath, or other breathing problems				24. Chronic (long-term) infection or other chronic diseases			
10. Lung disease (e.g., asthma)				25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring			
11. Kidney problems, kidney stones, or pain/problems with urination				26. Have you ever had a sleep test (e.g., sleep apnea)?			
12. Stomach, liver, or digestive problems				27. Have you ever spent a night in the hospital?			
13. Diabetes or blood sugar problems Insulin used				28. Have you ever had a broken bone?			
14. Anxiety, depression, nervousness, other mental health problems				29. Have you ever used or do you now use tobacco?			
15. Fainting or passing out				30. Do you currently drink alcohol?			
				31. Have you used an illegal substance within the past two years?			
				32. Have you ever failed a drug test or been dependent on an illegal substance?			

Other health condition(s) not described above: _____

Yes No Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: _____

Yes No Not Sure

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of [49 CFR 390.35](#), and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under [49 CFR 390.37](#) and [49 CFR 386](#) Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)***DRIVER HEALTH HISTORY REVIEW**

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).