DOT MEDICAL CARD

I certify that I have examined _____ in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when:

- ☐ wearing corrective lenses
- ☐ wearing hearing aid
- ☐ accompanied by a _____ waiver/exemption
- ☐ driving within an exempt intracity zone (49 CFR 391.62)
- ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER	TELEPHONE	DATE
MEDICAL EXAMINER'S NAME (PRINT)	☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse ☐ Other Practitioner	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE	NATIONAL. REGISTRY NO.	

SIGNATURE OF MEDICAL EXAMINER	INTRASTATE ONLY ☐ YES ☐ NO	CDL ☐ YES ☐ NO	DRIVER'S LICENSE NO.	DATE
SIGNATURE OF MEDICAL EXAMINER				
SIGNATURE OF MEDICAL EXAMINER				