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

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE

SIGNATURE OF DRIVER	DRIVER'S LICENSE NO.	STATE

ADDRESS OF DRIVER

MEDICAL CERTIFICATION EXPIRATION DATE