No Exams Conducted
Medical Examiners (MEs) must report to FMCSA, by close of business on the last day of the month, whenever the ME does not complete any examinations during that month.

Driver Examination Forms
MEs are required to continue to use the Medical Examination Report Form and Medical Examiner’s Certificate as found on the FMCSA website until December 22, 2015.

Provide Driver with Medical Examiner’s Certificate
MEs are required to continue to provide medically qualified commercial motor vehicle (CMV) drivers with a paper copy of the Medical Examiner’s Certificate.

Beginning June 22, 2018:
Electronic Notification of Medical Qualification to SDLAs
The MEC information for CLP/CDL applicants/holders will be electronically transmitted from the National Registry system to the SDLA, eliminating the need to issue a paper MEC to those drivers.

- MEs will still be required to provide the MEC, Form MCSA-5876 to non-CDL drivers and requesting employers, as currently required.

Daily Reporting
MEs are required to report results of each interstate CMV driver’s physical examination, including the results of examinations where the driver was found not to be qualified, to FMCSA by midnight local time of the next calendar day following the examination.

- Includes all CMV drivers (CLP/CDL and Non-CLP/CDL) who are required to be medically certified to operate in interstate commerce.
- For intrastate drivers in States that allow variances, the ME may transmit information about examinations performed in accordance with the Federal Motor Carrier Safety Regulations (FMCSRs) with any applicable State variances.

Not Medically Qualified
If the ME determines that the driver is not physically qualified to operate a CMV in accordance with § 391.41(b), the ME must:

- Inform the person examined of the determination.
- Inform the person examined that this information will be reported to FMCSA.

All MECs previously issued to the driver are invalid and no longer satisfy the requirements of § 391.41(a).

FMCSA will transmit this report to the SDLA. The driver will be required to be medically examined and certified before operating a CMV.

Beginning December 22, 2015:
Revised Driver Examination Forms
MEs are required to use the revised driver examination forms accessible from the National Registry and FMCSA websites:
- Medical Examination Report (MER) Form, MCSA-5875
- Medical Examiner’s Certificate (MEC), Form MCSA-5876

Results of examinations conducted on or after December 22, 2015 must be reported using the revised electronic CMV Driver Medical Examination Results Form, MCSA-5850. When entering results of examinations conducted on or after December 22, 2015, the National Registry system will automatically present the ME with the revised version of the CMV Driver Medical Examination Results Form, MCSA-5850.

Provide Driver with MEC
MEs are required to provide medically qualified CMV drivers with a paper copy of the MEC, Form MCSA-5876 so that Commercial Learner’s Permit (CLP)/Commercial Driver’s License (CDL) applicants/holders are able to provide a copy to the State Driver’s Licensing Agency (SDLA), and the non-CDL drivers are able to provide the documentation to their employers and Federal and State enforcement officials.

Determination Pending
The determination pending status allows the ME up to 45 days to obtain additional medical information and/or examination results in order to make a determination as to whether or not the driver is physically qualified to drive a CMV in accordance with § 391.41(b). If used the ME is required to inform the driver that:

- Additional information must be provided or further examination must be completed within 45 days.
- The Determination Pending status will be reported to FMCSA.

The driver may continue to operate a CMV if he/she has a current valid MEC.
If the requested information and examination results are not completed and provided to the ME within 45 days:

- The examination will no longer be valid.
- The driver is required to obtain a new examination in order to obtain a MEC, Form 5876.
I certify that I have examined Last Name: __________________________ First Name: __________________________ in accordance with (please check only one):

☐ 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 (check all that apply) OR

☐ 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), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):

☐ Wearing corrective lenses
☐ Wearing hearing aid
☐ Accompanied by a __________________________ waiver/exemption
☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
☐ Qualified by operation of 49 CFR 391.64 (Federal)
☐ Grandfathered from State requirements (State)

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name (please print or type)

☐ MD ☐ Physician Assistant
☐ DO ☐ Chiropractor
☐ Other Practitioner (specify)

Medical Examiner's State License, Certificate, or Registration Number

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

CLP/CDL Applicant/Holder

Driver's Address

Street Address: __________________________ City: __________________________ State/Province: __________________________ Zip Code: __________________________ ☐ Yes ☐ No
**PRIVACY ACT STATEMENT:** This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.

**AUTHORITY:** Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

**PURPOSE:** To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State.

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].

**ROUTINE USES:** The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA’s automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Preatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under “Preatory Statement of General Routine Uses” (available at http://www.dot.gov/privacy/privacyactnotices).

**ACKNOWLEDGMENT:** I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.

Driver’s Signature: __________________________________________ Date: ______________________

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

### PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
<th>Date of Birth:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address: __________________________________________ City: ______________________ State/Province: _____ Zip Code: ________

Driver’s License Number: ______________________ Issuing State/Province: _____ Phone: __________ Gender: ☐ M ☐ F

E-mail (optional): ______________________ ☐ CLP Applicant* ☐ CLP Holder* ☐ CDL Applicant* ☐ CDL Holder*

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. __________________________________________

(Attach additional sheets if necessary)
### DRIVER HEALTH HISTORY (continued)

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

**Other health condition(s) not described above:**

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

---

### 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).

(Attach additional sheets if necessary)
Last Name: ______________________  First Name: ______________________  Middle Initial: ___  DOB: __________  Exam Date: ________

### TESTING

<table>
<thead>
<tr>
<th>Pulse rate: __________</th>
<th>Pulse rhythm regular: ☐ Yes ☐ No</th>
<th>Height: ___ feet ___ inches</th>
<th>Weight: ___ pounds</th>
</tr>
</thead>
</table>

#### Blood Pressure

<table>
<thead>
<tr>
<th>Sitting</th>
<th>Second reading (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic</td>
<td>Diastolic</td>
</tr>
</tbody>
</table>

#### Urinalysis

<table>
<thead>
<tr>
<th>Sp. Gr.</th>
<th>Protein</th>
<th>Blood</th>
<th>Sugar</th>
</tr>
</thead>
</table>

Urine analysis is required. Numerical readings must be recorded.

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

#### Vision

**Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.**

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Uncorrected</th>
<th>Corrected</th>
<th>Horizontal Field of Vision</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Eye:</td>
<td>20/___</td>
<td>20/___</td>
<td>____ degrees</td>
<td></td>
</tr>
<tr>
<td>Left Eye:</td>
<td>20/___</td>
<td>20/___</td>
<td>____ degrees</td>
<td></td>
</tr>
<tr>
<td>Both Eyes:</td>
<td>20/___</td>
<td>20/___</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors.

**Monocular vision**

Referenced ophthalmologist or optometrist?

Received documentation from ophthalmologist or optometrist?

#### Hearing

**Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).**

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

**Whisper Test Results**

Record distance (in feet) from driver at which a forced whispered voice can first be heard:

<table>
<thead>
<tr>
<th>Right Ear</th>
<th>Left Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Audiometric Test Results**

<table>
<thead>
<tr>
<th>Right Ear</th>
<th>Left Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>500 Hz</td>
<td>1000 Hz</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

Average (right): ___ Average (left): ___

### PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

<table>
<thead>
<tr>
<th>Body System</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Skin</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Eyes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Ears</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Mouth/throat</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Cardiovascular</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Lungs/chest</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

8. Abdomen

9. Genito-urinary system including hernias

10. Back/Spine

11. Extremities/joints

12. Neurological system including reflexes

13. Gait

14. Vascular system

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)
Last Name: ___________________________ First Name: ___________________________ Middle Initial: _______ DOB: ___________ Exam Date: ___________.

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: __________.
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 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: