

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined

First Name

Last Name

Social Security Number: _____

In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41 - 39) and with knowledge of his/her duties, I find him/her qualified under the regulations.

_____ Qualified only when wearing corrective lenses.

_____ Qualified only when wearing a hearing aid.

_____ Medically unqualified unless accompanied by a _____ waiver.

_____ Medically unqualified unless driving within an exempt intracity zone.

_____ Qualified by operation of 49 CFR 391.64.

A completed examination form for this person is on file in my office at

(Telephone Number)

(Date Completed)

(Name of Medical Examiner)

(Title)

(CDL Expiration Date)

(License Number)

(State in Which Licensed)

(Signature of Medical Examiner)

(Signature of Driver)

(Address of Driver)

(City)

(State)

(Zipcode)