Please keep this card for your record do not mail to the DMV.

MEDICAL EXAMINER'S CERTIFICATE

B-328 Rev. 11-2013

STATE OF CONNECTICUT - **DMV**
On The Web At ct.gov/dmv

I CERTIFY THAT I HAVE EXAMINED *(Print Name of Individual Below)*

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
- ☐ Qualified by operation of 49 CFR 391.64
- ☐ Driving within an exempt intracity zone (49 CFR 391.62)
- ☐ Accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ Accompanied by a ___________________________ waiver/exemption

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 NO.**	**DATE**
X		

MEDICAL EXAMINER'S NAME *(Please Print Clearly)*	☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse ☐ Other Practitioner

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

SIGNATURE OF DRIVER	**INTRASTATE ONLY**	**CDL**	**DRIVER'S LICENSE NO.**	**STATE**
X	☐ Yes ☐ No	☐ Yes ☐ No		

ADDRESS OF DRIVER	**MEDICAL CERTIFICATION EXPIRATION DATE**