## DOT MEDICAL CERTIFICATE



I certify I have examined: the Federal Motor Carrier Safety Regulations (4 person qualified, and if applicable, only when:		d with knowledg	e of the	in acd	cordance uties, I f	with with this	
□ Wearing corrective lenses     □ Wearing a hearing aid     □ Accompanied by a waiver/exemp	☐ Accompa	☐ Driving with an exempt intercity 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		DA	TE		
MEDICAL EXAMINER'S NAME (PRINT)		□MD	□D0	□PA	□DC	APN	
MEDICAL EXAMINER'S CERTIFICATE NUMBER / AND ISSUING STATE		DOT MEDICAL CERTIFICATE EXPIRATION DATE					
SIGNATURE OF DRIVER		DRIVER'S LICENSE NUMBER					
ISSUING STATE	DRIVER'S PHONE NUMBER						
CDL MEDICAL CARD REV 02/11		THI	S CARD IS	NOT FOR	RESALE.	_	