MEDICAL EXAMINER'S CERTIFICATE

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
- ☐ Non-commerical class C driver operating a CMV 10,001 to 26,000 lbs., Intrastate (MD Motor Vehicle Law 25-111(i)(v)

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 ☐ Other Practitioner	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE	NATIONAL REGISTRY NO.			
SIGNATURE OF DRIVER	INTRASTATE ONLY ☐ YES ☐ NO	CDL ☐ YES ☐ NO	DRIVER'S LICENSE NO.	STATE
ADDRESS OF DRIVER				
MEDICAL CERTIFICATE EXPIRATION DATE				

DISCLAIMER: IT IS THE SOLE RESPONSIBILITY OF THE PERSON(S) COMPLETING THIS CERTIFICATE TO COMPLY WITH ALL REQUIREMENTS CONTAINED IN THE DEPARTMENT OF TRANSPORTATION FEDERAL MOTOR CARRIERS SAFETY ADMINISTRATION REGULATIONS 49 CFR PART 391 QUALIFICATIONS OF DRIVERS.

MEDICAL EXAMINER'S CERTIFICATE

DRIVER'S NAME

MEDICAL CERTIFICATE EXPIRATION DATE