OMB No.: 2126-0006 Expiration Date: 12/31/2024

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OM8 Control Number. The OM8 Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

U.S. Department of Transportation Federal Motor Carrier Safety Administration

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #
(or sticker)

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

PERSONAL INFORMATION					
Last Name:	First Name:	Middle Initial:	Date of Birth:		Age:
Street Address:	City:	Sta	te/Province:	Zip Code	:
Driver's License Number:	Issuin	g State/Province:		Phone:	
E-Mail (optional):		CLP/CDL Applicant/Ho	lder*: O Yes O No)	
		Driver ID Verified By**:			
Has your USDOT/FMCSA medical cert	ificate ever been denied or issued fo	r less than 2 years? O Yes	O No O Not Sure		
"CLP/CDL Applicant/Holder: See instructions for definitions.		**Driver ID Verified By: Record what type of phot	o ID was used to verify the identity of t	ne driver, e.g., CDL,	driver's license, passport.
DRIVER HEALTH HISTORY					
Have you ever had surgery? If "yes," pl	ease list and explain below.		OY	es () No	O Not Sure
Are you currently taking medications	(prescription, over-the-counter, herbal r	emedies, diet supplements)?	01	es O No	O Not Sure
If "yes," please describe below.					ı
					W. A. S.

(Attach additional sheets if necessary)

^{**}This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.**

Do you have or have you ever had: Yes Vo Sure 1. Head/brain injuries or illnesses (e.g., concussion) 2. Seizures/epilepsy 3. Eye problems (except glasses or contacts) 4. Ear and/or hearing problems 5. Heart disease, heart attack, bypass, or other heart problems 6. Pacemaker, stents, implantable devices, or other heart procedures 7. High blood pressure 8. High cholesterol 9. Chronic (long-term) cough, shortness of breath, or other breathing problems 10. Lung disease (e.g., asthma) 11. Kidney problems, kidney stones, or pain/problems with urination 12. Stomach, liver, or digestive problems 13. Diabetes or blood sugar problems 14. Anxiety, depression, nervousness, other mental health problems 15. Heart diseases (e.g., asthma) 16. Dizziness, headaches, numbness, tingling, or memory loss 17. Unexplained weight loss 18. Stroke, mini-stroke (TIA), paralysis, or weakness 19. Missing or limited use of arm, hand, finger, leg, foot, toe 20. Neck or back problems 20. Neck or back problems 21. Bone, muscle, joint, or nerve problems 22. Blood clots or bleeding problems 23. Cancer 24. Chronic (long-term) infection or other chronic diseases 25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snorting 26. Have you ever had a sleep test (e.g., sleep apnea)? 27. Have you ever had a broken bone? 28. Have you ever spent a night in the hospital? 29. Have you ever used or do you now use tobacco? 29. Have you ever used or do you now use tobacco? 29. Have you used an illegal substance within the past two years?	Last Name: First Na	me:			DOB: Exam Date:			
Do you have or have you ever had: Ver No Sure Nead/brain injuries or illnesses (r.g., concussion) 3. Eye problems (except glosses or contacts) 3. Eye problems (except glosses or contacts) 3. Eye problems (except glosses or contacts) 4. Ear and/or hearing problems 5. Heart disease, heart attack, bypass, or other heart problems 6. Pacemaker, stents, implantable devices, or other heart procedures 6. Pacemaker, stents, implantable devices, or other heart procedures 6. Pacemaker, stents, implantable devices, or other heart procedures 6. Pacemaker, stents, implantable devices, or other heart procedures 7. High blood pressure 8. O O O O O O O O O O O O O O O O O O O	DRIVER HEALTH HISTORY (continued)							
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Other health condition(s) not described above: O Yes O No O Not Sure Other health condition(s) not described above: O Yes O No O Not Sure (Attach additional sheets if necessary) CMV DRIVER'S SIGNATURE Lectify 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: Date: ECTION 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).		lth O	_	_	31. Have you used an illegal substance within the past	Ŏ	_	Ō
Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: (Attach additional sheets if necessary) 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: ECTION 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).	15. Fainting or passing out	0	0	0		0	0	0
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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: ECTION 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 she	ets if r	neces.	sary)
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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).	SECTION 2. Examination Report (to be filled out by the r	nedical e.	xamii	ner)		-	77 3888 7788	// ·
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(Assach additional density)								
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Last Name:		First Name: _			ООВ:		_ Exam Date	2:	
TESTING									
Pulse Rate:	Pulse rhythm regular:	O Yes O No		Height:	_feetind	ches Weight:	pounds		
Blood Pressure	Systolic	Diast	olic	Urinalysis	;	Sp. Gr.	Protein	Blood	Sugar
Sitting				Urinalysis	is required.				
Second reading (optional)				Numerica must be re	readings				
Other testing if indicat	ed					n the urine may nedical problem		on for further	testing to
				raie out ari	y undenying i	пеака ртоотет	L.		
			<u></u>						
At least 70° field of vision) acuity (Snellen) in each eye in horizontal meridian meas e noted on the Medical Exar	ured in each eye	. The use of			rive whispered vo or equal to 40 dB,			
l .	corrected Corrected			Check if h	earing aid u	sed for test:	Right Ear	Left Ear	☐ Neither
Right Eye: 20,	/ 20/	Right Eye:	degrees	-	est Results			_	Ear Left Ear
		Left Eye:	_			t) from driver a rst be heard	t which a for	ced	
i ·	/ 20/	•	Yes No	OR					
Applicant can recognized signals and devices should be seen as a s	ze and distinguish among owing red, green, and am	traffic control ber colors		Audiome Right Ear:	tric Test Res	ults	Left Ear:		
Monocular vision			0 0		1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Referred to ophthalmo	ologist or optometrist?		0 0				<u> </u>		<u></u>
Received documentati	on from ophthalmologist	or optometris	t? O O	Average (right):		Average (le	eft):	
PHYSICALEXAMINA	TION								
The presence of a cert worsen, or is readily ar temporarily. Also, the condition could result	ain condition may not ne menable to treatment. Ev driver should be advised in a more serious illness t	en if a conditio to take the nec	n does not d essary steps	isqualify a d	river, the Me	dical Examine	r may consid	er deferring	the driver
Check the body system	ns for abnormalities.	N1	6.1	D. J. C.				Name	
Body System 1. General			Abnormal O	Body Sys 8. Abdor				Norma	I Abnormal O
2. Skin		000000	0	9. Genito	-urinary sys	tem including	hernias	ŏ	0
3. Eyes 4. Ears		0	000	10. Back/s	pine nities/joints			000000	0000
5. Mouth/throat		ŏ	ŏ			m including re	flexes	ŏ	ŏ
6. Cardiovascular		0	Ō	13. Gait				0	Q
7. Lungs/chest	movement in datail in the armage	_		14. Vascul	•		- CMU	O	O
	nswers in detail in the space mber before each comment		ate wnetner it	woula апест	tne arivers at	ollity to operate d	a CIVIV.		
							(Attach ada	itional sheet	s if necessary)

Form MCSA-5875 OMB No.: 2126-0006 Expiration Date: 12/31/202-

POFM IVICSA-38/3			OMB No.: 2126-00	106 Expiration Date: 12/31/20
Last Name:	First Name:	DOB;	Exam Da	ate:
Please complete only one of the follow	ving (Federal or State) Medical Exa	miner Determination sections:		
MEDICAL EXAMINER DETERMINAT	ION (Federal)			
Use this section for examinations perforr	ned in accordance with the Federal M	otor Carrier Safety Regulations (<u>49 (</u>	<u> TFR 391.41-391.49</u>	y:
O Does not meet standards (specify red	ison):			
O Meets standards in 49 CFR 391.41; c	jualifies for 2-year certificate			
O Meets standards, but periodic moni	toring required (specify reason):			
Driver qualified for: O 3 months	O 6 months O 1 year O other (s	specify):		
☐ Wearing corrective lenses ☐	•	, , ,		
Accompanied by a Skill Performa		Qualified by operation of 49 CF	<u>R 391.64</u> (Federal)	
Driving within an exempt intraci	•			
O Determination pending (specify reas				
Return to medical exam office fo				
☐ Medical Examination Report am				
	ner's Signature:			_
O Incomplete examination (specify rea	son):			
If the driver meets the standards ou	tlined in <u>49 CFR 391.41,</u> then complete	a Medical Examiner's Certificate as s	tated in <u>49 CFR 39</u> 1	<u>1.43(h)</u> , as appropriate.
I have performed this evaluation for ce evaluation, and attest that, to the best			ed information po	ertaining to this
Medical Examiner's Signature:				
Medical Examiner's Name (please print o	or type): Michael A. Welsh, MD			
Medical Examiner's Address: 305 Nor	th River Ave / PO Box 1268	City: Buckley	_ State: WA	Zip Code: 98321
Medical Examiner's Telephone Number	r: (360) 829-0625	Date Certificate Signed: _		
Medical Examiner's State License, Certi	ficate, or Registration Number:	MD00026055WA		Issuing State: WA
☑ MD ☐ DO ☐ Physician Assistan	t 🔲 Chiropractor 🔲 Advanced Pra	ctice Nurse		
Other Practitioner (specify):				

Medical Examiner's Certificate Expiration Date:

National Registry Number: 4193446351

Form MCSA-5875

OMB No.: 2126-0006 Expiration Date: 12/31/2024

Last Name:	First Name:	DOB:	Exam Da	ate:
MEDICAL EXAMINER DETI	ERMINATION (State)			
	ons performed in accordance with the Federal Mo valid for intrastate operations);	tor Carrier Safety Regulations (<u>49 (</u>	CFR 391.41-391.49)) with any applicable State
O Does not meet standards	in <u>49 CFR 391,41</u> with any applicable State varia	ances (specify reason):		
O Meets standards in 49 CF	R 391.41 with any applicable State variances			
O Meets standards, but peri	iodic monitoring required (specify reason):			
Driver qualified for: O 3	months O 6 months O 1 year O other (sp	ecify):		
☐ Wearing corrective len	nses 🔲 Wearing hearing aid 🔲 Accom	npanied by a waiver/exemption (specify type):	
Accompanied by a Ski	Ill Performance Evaluation (SPE)Certificate	Grandfathered from State requi	rements (State)	
If the driver meets the stan	ndards outlined in <u>49 CFR 391.41</u> , with applicable St	ate variances, then complete a Mec	lical Examiner's Ce	rtificate, as appropriate.
	tion for certification. I have personally reviewed o the best of my knowledge, I believe it to be tru		ed information pe	ertaining to this
Medical Examiner's Signature	e:	·		
Medical Examiner's Name (pl	lease print or type): Michael A Welsh, MD			
Medical Examiner's Address:	305 North River / PO Box 1268	City: Buckley	_ State: WA	Zip Code: 98321
Medical Examiner's Telephor	ne Number: <u>(360)</u> 829-0625	Date Certificate Signed: _		
Medical Examiner's State Lice	ense, Certificate, or Registration Number:	MD00026055WA		_ Issuing State: <u>WA</u>
☑ MD ☐ DO ☐ Physicia	ın Assistant 🔲 Chiropractor 🔲 Advanced Prac	tice Nurse		
Other Practitioner (specify	ý):			
National Registry Number: _	4193446351	Medical Examiner's Certific	cate Expiration D	ate:

OMB No.: 2126-0006 Expiration Date: 12/31/2024

Form MCSA-5876

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately one minute per response, including the time for reviewing instructions, gathering the data needed and completing and reviewing the collection of information. All responses to this collection of information, including suggestions for reducing this burden to: Information Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, 5E, Washington, D.C. 20590. **MEDICAL EXAMINER'S CERTIFICATE** (for Commercial Driver Medical Certification) U.S. Department of Transportation Federal Motor Carrier Safety Administration Public Burden Statement

CMV DRIVER CERTIFICATION		
I certify that I have examined (last name)	in accordance with (please check only one):	ase check only one):
• the Federal Motor Carrier Safety Regulations (49 CFR 391 ±1-391 49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) OR driving duties, I find this person is qualified, and, if applicable, only when (check all that apply)	e driving duties, I find this person is qualified, and, if app rariances (which will only be valid for intrastate operatio	licable, only when <i>(check all that apply) OR</i> ns), and, with knowledge of the
☐ Wearing corrective lenses ☐ Accompanied by a waiver/exemption (specify type):	Driving within an ex	Driving within an exempt intracity zone (49 CFR 391 62) (Federal)
☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate		\square Qualified by operation of $49.CFR.391.64$ (Federal) \square 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 Certificate Expiration Date
MEDICAL EXAMINER INFORMATION		
Medical Examiner's Signature	Medical Examiner's Telephone Number Dat (360) 829 0625	Date Certificate Signed
Medical Examiner's Name (please print or type) Michael A. Welsh, MD	MD O Physician Assistant O Advanced Practice Nurse DO O Chiropractor O Other Practitioner (specify)	actice Nurse oner (specify)
Medical Examiner's State License, Certificate, or Registration Number MD00026055WA	State	National Registry Number 4193446351
CMV DRIVER INFORMATION		
Driver's Signature	Driver's License Number	Issuing State/Province
Driver's Address Street Address: City:	State/Province: Zip Code:	CLP/CDL Applicant/Holder

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