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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: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Issuing State/Province: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail (optional): \_\_\_\_\_ CLP/CDL Applicant/Holder\*: Yes No

Driver ID Verified By\*\*: \_\_\_\_\_

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? Yes No Not Sure

\*CLP/CDL Applicant/Holder: See instructions for definitions.

\*\*Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

**DRIVER HEALTH HISTORY**

Have you ever had surgery? If "yes," please list and explain below. Yes No Not Sure

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? Yes No Not Sure  
If "yes," please describe below.

\*\*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.\*\*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**DRIVER HEALTH HISTORY** *(continued)*

| Do you have or have you ever had:                                              | Yes | No | Not Sure | Do you have or have you ever had:                                                       | Yes | No | Not Sure |
|--------------------------------------------------------------------------------|-----|----|----------|-----------------------------------------------------------------------------------------|-----|----|----------|
| 1. Head/brain injuries or illnesses (e.g., concussion)                         |     |    |          | 16. Dizziness, headaches, numbness, tingling, or memory loss                            |     |    |          |
| 2. Seizures/epilepsy                                                           |     |    |          | 17. Unexplained weight loss                                                             |     |    |          |
| 3. Eye problems (except glasses or contacts)                                   |     |    |          | 18. Stroke, mini-stroke (TIA), paralysis, or weakness                                   |     |    |          |
| 4. Ear and/or hearing problems                                                 |     |    |          | 19. Missing or limited use of arm, hand, finger, leg, foot, toe                         |     |    |          |
| 5. Heart disease, heart attack, bypass, or other heart problems                |     |    |          | 20. Neck or back problems                                                               |     |    |          |
| 6. Pacemaker, stents, implantable devices, or other heart procedures           |     |    |          | 21. Bone, muscle, joint, or nerve problems                                              |     |    |          |
| 7. High blood pressure                                                         |     |    |          | 22. Blood clots or bleeding problems                                                    |     |    |          |
| 8. High cholesterol                                                            |     |    |          | 23. Cancer                                                                              |     |    |          |
| 9. Chronic (long-term) cough, shortness of breath, or other breathing problems |     |    |          | 24. Chronic (long-term) infection or other chronic diseases                             |     |    |          |
| 10. Lung disease (e.g., asthma)                                                |     |    |          | 25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring |     |    |          |
| 11. Kidney problems, kidney stones, or pain/problems with urination            |     |    |          | 26. Have you ever had a sleep test (e.g., sleep apnea)?                                 |     |    |          |
| 12. Stomach, liver, or digestive problems                                      |     |    |          | 27. Have you ever spent a night in the hospital?                                        |     |    |          |
| 13. Diabetes or blood sugar problems<br>Insulin used                           |     |    |          | 28. Have you ever had a broken bone?                                                    |     |    |          |
| 14. Anxiety, depression, nervousness, other mental health problems             |     |    |          | 29. Have you ever used or do you now use tobacco?                                       |     |    |          |
| 15. Fainting or passing out                                                    |     |    |          | 30. Do you currently drink alcohol?                                                     |     |    |          |
|                                                                                |     |    |          | 31. Have you used an illegal substance within the past two years?                       |     |    |          |
|                                                                                |     |    |          | 32. Have you ever failed a drug test or been dependent on an illegal substance?         |     |    |          |

| Other health condition(s) not described above: | Yes | No | Not Sure |
|------------------------------------------------|-----|----|----------|
| <div></div>                                    |     |    |          |

| Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: | Yes | No | Not Sure |
|----------------------------------------------------------------------------------------------------------------|-----|----|----------|
| <div></div>                                                                                                    |     |    |          |

**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: \_\_\_\_\_

**SECTION 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).

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**TESTING**

Pulse Rate: \_\_\_\_\_ Pulse rhythm regular: Yes No Height: \_\_\_\_ feet \_\_\_\_ inches Weight: \_\_\_\_ pounds

**Blood Pressure**

Systolic

Diastolic

Sitting

Second reading  
(optional)**Urinalysis**

Sp. Gr.

Protein

Blood

Sugar

Urinalysis is required.  
Numerical readings  
must be recorded.

Other testing if indicated

*Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.***Vision***Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.*

| Acuity     | Uncorrected | Corrected | Horizontal Field of Vision |
|------------|-------------|-----------|----------------------------|
| Right Eye: | 20/ _____   | 20/ _____ | Right Eye: _____ degrees   |
| Left Eye:  | 20/ _____   | 20/ _____ | Left Eye: _____ degrees    |
| Both Eyes: | 20/ _____   | 20/ _____ | Yes No                     |

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors

Monocular vision

Referred to ophthalmologist or optometrist?

Received documentation from ophthalmologist or optometrist?

**Hearing***Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

| Check if hearing aid used for test:                                                        | Right Ear | Left Ear | Neither |
|--------------------------------------------------------------------------------------------|-----------|----------|---------|
| <b>Whisper Test Results</b>                                                                |           |          |         |
| Record distance (in feet) from driver at which a forced whispered voice can first be heard | _____     | _____    | _____   |

**OR****Audiometric Test Results**

| Right Ear:             |         |         | Left Ear:             |         |         |
|------------------------|---------|---------|-----------------------|---------|---------|
| 500 Hz                 | 1000 Hz | 2000 Hz | 500 Hz                | 1000 Hz | 2000 Hz |
| _____                  | _____   | _____   | _____                 | _____   | _____   |
| Average (right): _____ |         |         | Average (left): _____ |         |         |

**PHYSICAL EXAMINATION**

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

**Body System**

Normal Abnormal

1. General
2. Skin
3. Eyes
4. Ears
5. Mouth/throat
6. Cardiovascular
7. Lungs/chest

**Body System**

Normal Abnormal

8. Abdomen
9. Genito-urinary system including hernias
10. Back/spine
11. Extremities/joints
12. Neurological system including reflexes
13. Gait
14. Vascular system

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**Please complete only one of the following (Federal or State) Medical Examiner Determination sections:**

### MEDICAL EXAMINER DETERMINATION (Federal)

*Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):*

Does not meet standards (specify reason): \_\_\_\_\_

Meets standards in [49 CFR 391.41](#); qualifies for 2-year certificate

Meets standards, but periodic monitoring required (specify reason): \_\_\_\_\_

Driver qualified for: 3 months 6 months 1 year other (specify): \_\_\_\_\_

Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): \_\_\_\_\_

Accompanied by a Skill Performance Evaluation (SPE) Certificate

Driving within an exempt intracity zone (see [49 CFR 391.62](#)) (Federal)

Determination pending (specify reason): \_\_\_\_\_

Return to medical exam office for follow-up on (must be 45 days or less): \_\_\_\_\_

Medical Examination Report amended (specify reason): \_\_\_\_\_

(if amended) Medical Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Incomplete examination (specify reason): \_\_\_\_\_

**If the driver meets the standards outlined in [49 CFR 391.41](#), then complete a Medical Examiner's Certificate as stated in [49 CFR 391.43\(h\)](#), as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: \_\_\_\_\_

Medical Examiner's Name (please print or type): \_\_\_\_\_

Medical Examiner's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Medical Examiner's Telephone Number: \_\_\_\_\_ Date Certificate Signed: \_\_\_\_\_

Medical Examiner's State License, Certificate, or Registration Number: \_\_\_\_\_ Issuing State: \_\_\_\_\_

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): \_\_\_\_\_

National Registry Number: \_\_\_\_\_

Medical Examiner's Certificate Expiration Date:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**MEDICAL EXAMINER DETERMINATION (State)**

*Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations ([49 CFR 391.41-391.49](#)) with any applicable State variances (which will only be valid for intrastate operations):*

Does not meet standards in [49 CFR 391.41](#) with any applicable State variances (*specify reason*): \_\_\_\_\_Meets standards in [49 CFR 391.41](#) with any applicable State variancesMeets standards, but periodic monitoring required (*specify reason*): \_\_\_\_\_Driver qualified for:    3 months    6 months    1 year    other (*specify*): \_\_\_\_\_Wearing corrective lenses    Wearing hearing aid    Accompanied by a waiver/exemption (*specify type*): \_\_\_\_\_Accompanied by a Skill Performance Evaluation (SPE) Certificate    Grandfathered from State requirements (*State*)**If the driver meets the standards outlined in [49 CFR 391.41](#), with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: \_\_\_\_\_

Medical Examiner's Name (*please print or type*): \_\_\_\_\_

Medical Examiner's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Medical Examiner's Telephone Number: \_\_\_\_\_ Date Certificate Signed: \_\_\_\_\_

Medical Examiner's State License, Certificate, or Registration Number: \_\_\_\_\_ Issuing State: \_\_\_\_\_

MD    DO    Physician Assistant    Chiropractor    Advanced Practice Nurse

Other Practitioner (*specify*): \_\_\_\_\_

National Registry Number: \_\_\_\_\_

Medical Examiner's Certificate Expiration Date:

# Instructions for Completing the Medical Examination Report Form (MCSA-5875)

## I. Step-By-Step Instructions

### Driver:

#### Section 1: Driver Information

- **Personal Information:** Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, driver's license number and issuing state.
  - **CLP/CDL Applicant/Holder:** Check "yes" if you are a commercial learner's permit (**CLP**) or commercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
  - **Driver ID Verified By:** The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
  - **Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box "yes" or "no" and if you aren't sure check the "not sure" box.
- **Driver Health History:**
  - **Have you ever had surgery:** Please check "yes" if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
  - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check "yes" if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
  - **#1-32:** Please complete this section by checking the "yes" box to indicate that you have, or have ever had, the health condition listed or the "No" box if you have not. Check the "not sure" box if you are unsure.
  - **Other Health Conditions not described above:** If you have, or have had, any other health conditions not listed in the section above, check "Yes" and in the box provided and list those condition(s).
  - **Any yes answers to questions #1-32 above:** If you have answered "yes" to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered "yes" to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked "yes" to question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

## Medical Examiner:

### Section 2: Examination Report

- **Driver Health History Review:** Review answers provided by the driver in the driver health history section and discuss any “yes” and “not sure” responses. In addition, be sure to compare the medication list to the health history responses ensuring that the medication list matches the medical conditions noted. Explore with the driver any answers that seem unclear. Record any information that the driver omitted. As the Medical Examiner conducting the driver’s physical examination you are required to complete the entire medical examination even if you detect a medical condition that you consider disqualifying, such as deafness. Medical Examiners are expected to determine the driver’s physical qualification for operating a commercial vehicle safely. Thus, if you find a disqualifying condition for which a driver may receive a Federal Motor Carrier Safety Administration medical exemption, please record that on the driver’s Medical Examiner’s Certificate, Form MCSA-5876, as well as on the Medical Examination Report Form, MCSA-5875.
- **Testing:**
  - **Pulse rate and rhythm, height, and weight:** record these as indicated on the form.
  - **Blood Pressure:** record the blood pressure (systolic and diastolic) of the driver being examined. A second reading is optional and should be recorded if found to be necessary.
  - **Urinalysis:** record the numerical readings for the specific gravity, protein, blood and sugar.
  - **Vision:** The current vision standard is provided on the form. When other than the Snellen chart is used, give test results in Snellen-comparable values. When recording distance vision, use 20 feet as normal. Record the vision acuity results and indicate if the driver can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors; has monocular vision; has been referred to an ophthalmologist or optometrist; and if documentation has been received from an ophthalmologist or optometrist.
  - **Hearing:** The current hearing standard is provided on the form. Hearing can be tested using either a whisper test or audiometric test. Record the test results in the corresponding section for the test used.
- **Physical Examination:** Check the body systems for abnormalities and indicate normal or abnormal for each body system listed. Discuss any abnormal answers in detail in the space provided and indicate whether it would affect the driver’s ability to safely operate a commercial motor vehicle.

***In this next section, you will be completing either the Federal or State determination, not both.***

- **Medical Examiner Determination (Federal):** Use this section for examinations performed in accordance with the FMCSRs ([49 CFR 391.41-391.49](#)). Complete the medical examiner determination section completely. When determining a driver’s physical qualification, please note that English language proficiency ([49 CFR part 391.11](#): General qualifications of drivers) is not factored into that determination.
  - **Does not meet standards:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in [49 CFR 391.41](#).
  - **Meets standards in [49 CFR 391.41](#); qualifies for 2-year certification:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner’s Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting “other” specify the time frame.
  - **Determination that driver meets standards:** Select all categories that apply to the driver’s certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, driving within an exempt intracity zone, etc.).
- **Determination pending:** Select this option when more information is needed to make a qualification decision and specify a date, on or before the 45 day expiration date, for the driver to return to the medical exam office for follow-up. This will allow for a delay of the qualification decision for as many as 45 days. If the disposition of the pending examination is not updated via the National Registry on or before the 45 day expiration date, FMCSA will notify the examining medical examiner and the driver in writing that the examination is no longer valid and that the driver is required to be re-examined.
  - **MER amended:** A Medical Examination Report Form (MER), MCSA-5875, may only be amended while in determination pending status for situations where new information (e.g., test results, etc.) has been received or there has been a change in the driver’s medical status since the initial examination, but prior to a final qualification determination. Select this option when a Medical Examination Report Form, MCSA-5875, is being amended; provide the reason for the amendment, sign and date. In addition, initial and date any changes made on the Medical Examination Report Form, MCSA-5875. A Medical Examination Report Form, MCSA-5875, cannot be amended after an examination has been in determination pending status for more than 45 days or after a final qualification determination has been made. The driver is required to obtain a new physical examination and a new Medical Examination Report Form, MCSA-5875, should be completed.
- **Incomplete examination:** Select this when the physical examination is not completed for any reason (e.g., driver decides they do not want to continue with the examination and leaves) other than situations outlined under determination pending.
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner’s Certificate Expiration Date:** Enter the date the **driver’s** Medical Examiner’s Certificate (MEC) expires.
- **Medical Examiner Determination (State):** Use this section for examinations performed in accordance with the FMCSRs ([49 CFR 391.41-391.49](#)) with any applicable State variances (which will only be valid for intrastate operations). Complete the medical examiner determination section completely.
  - **Does not meet standards in [49 CFR 391.41](#) with any applicable State variances:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in [49 CFR 391.41](#) with any applicable State variances.
  - **Meets standards in [49 CFR 391.41](#) with any applicable State variances:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner’s Certificate.



- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting “other” specify the time frame.
  - **Determination that driver meets standards:** Select all categories that apply to the driver’s certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, etc.).
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner’s Certificate Expiration Date:** Enter the date the **driver’s** Medical Examiner’s Certificate (MEC) expires.

- II. **If updating an existing exam, you must resubmit the new exam results, via the Medical Examination Results Form, MCSA-5850, to the National Registry, and the most recent dated exam will take precedence.**
- III. **To obtain additional information regarding this form go to the Medical Program’s page on the Federal Motor Carrier Safety Administration’s website at <http://www.fmcsa.dot.gov/regulations/medical>.**