Public Burden Statement

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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:							
Street Address:		City:		State/Province: _		Zip Code: _	
Driver's License Number:		Issuing State	e/Province:	Phone:		Gender:	ОМОБ
E-mail (optional):			CLP/CDL Applicant	/Holder*: O Yes	○ No		
			Driver ID Verified By				
Has your USDOT/FMCSA medical certific	cate ever been denied or	issued for less tha	in 2 years? O Yes(○ No ○ Not Sure			
*CLP/CDL Applicant/Holder: See instructions for definitions.		**Driv	er ID Verified By: Record what type	of photo ID was used to verify the	e identity of the dr	iver, e.g., CDL, driver's	s license, passport.
DRIVER HEALTH HISTORY							
Have you ever had surgery? If "yes," plea	ase list and explain below	<i>!</i> .			O Y	es 🔾 No 🔾	Not Sure
Are you currently taking medications If "yes," please describe below.	(prescription, over-the-cou	unter, herbal remed	ies, diet supplements)?	?	0	Yes ○ No○	Not Sure

(Attach additional sheets if necessary)

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ast Name: First Name:					DOB: Exam Date:								
DRIVER HEALTH HISTORY (continued)													
Do you have or have you ever had:		Yes	No	Not Sure		Yes	No	Not Sure					
1. Head/brain injuries or illnesses (e.g., concu	ssion)	0	0	0	16. Dizziness, headaches, numbness, tingling, or memory	0	0	0					
2. Seizures, epilepsy		Ō	Ō	Ō	loss								
3. Eye problems (except glasses or contacts)		Ō	Ō	Ō	17. Unexplained weight loss	0	0	0					
4. Ear and/or hearing problems		Ō	Ō	Ō	18. Stroke, mini-stroke (TIA), paralysis, or weakness	0	0	0					
5. Heart disease, heart attack, bypass, or oth problems	er heart	0	0	0	19. Missing or limited use of arm, hand, finger, leg, foot, toe20. Neck or back problems	0	0	0					
6. Pacemaker, stents, implantable devices, or procedures	other heart	0	0	0	21. Bone, muscle, joint, or nerve problems22. Blood clots or bleeding problems	0	0	0					
7. High blood pressure		0	0	0	23. Cancer		0	0					
8. High cholesterol		Ō	Õ	Õ		0	0	0					
9. Chronic (long-term) cough, shortness of b	reath, or other	\tilde{O}	Ö	$\hat{\circ}$	24. Chronic (long-term) infection or other chronic diseases	0	0	0					
breathing problems 10. Lung disease (e.g., asthma)	readily of ourself	0	_	0	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	0	0	0					
11. Kidney problems, kidney stones, or pain/pi	ohlems with		0	0	26. Have you ever had a sleep test (e.g., sleep apnea)?	0	0	0					
urination	ONICHIS WILLI	\cup	\cup	\cup	27. Have you ever spent a night in the hospital?	0	0	0					
12. Stomach, liver, or digestive problems		0	0	0	28. Have you ever had a broken bone?	0	0	0					
13. Diabetes or blood sugar problems		$\tilde{\circ}$	Ö	Ô	29. Have you ever used or do you now use tobacco?	0	0	0					
Insulin used		$\tilde{\circ}$	Ô	$\tilde{\circ}$	30. Do you currently drink alcohol?	0	0	0					
14. Anxiety, depression, nervousness, other m	ental health	Ö	0	Ö	31. Have you used an illegal substance within the past two years?	0	0	0					
15. Fainting or passing out		0	0	0	32. Have you ever failed a drug test or been dependent on an illegal substance?	0	0	0					
							ı						
Did you answer "yes" to any of questions 1-32	?? If so, please co	mme	ent fu	urther	on those health conditions below. Yes ON	• ()	Not	Sure					
					(Attach additional shee	ts if n	ecesso	arv)					
CMV DRIVER'S SIGNATURE								7/					
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 a	out by the medical	exar	niner)		2/2010/02/2020							
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 sheets if necessary,											