Form MCSA-5876 (Revised: 12/06/2015) OMB No. 2126-0006 Expiration Date: 8/31/2018

**Medical Examiner's Certificate**
(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: ___________ First Name: ___________ in accordance with (please check only one):

- 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 (check all that apply) OR
- 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), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):
  - Wearing corrective lenses
  - Wearing hearing aid
  - Accompanied by a ______________________ waiver/exemption
  - Accompanied by a Skill Performance Evaluation (SPE) Certificate
  - Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
  - Qualified by operation of 49 CFR 391.64 (Federal)
  - 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.

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**Medical Examiner's Certificate Expiration Date**

**Medical Examiner's Signature**

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

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**Medical Examiner's State License, Certificate, or Registration Number**

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**Medical Examiner's Telephone Number**

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**Date Certificate Signed**

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**Issuing State**

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**National Registry Number**

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**Driver's Signature**

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**Driver's License Number**

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**Issuing State/Province**

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**CLP/CDL Applicant/Holder**

- Yes
- No