

**Medical Examination Report Form**

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

For commercial and non-commercial drivers

1. Driver's Name: \_\_\_\_\_  
2. Driver's License Number: \_\_\_\_\_  
3. Driver's License State: \_\_\_\_\_  
4. Driver's License Expiration Date: \_\_\_\_\_  
5. Driver's License Class: \_\_\_\_\_  
6. Driver's License Category: \_\_\_\_\_  
7. Driver's License Endorsement: \_\_\_\_\_  
8. Driver's License Restriction: \_\_\_\_\_  
9. Driver's License Status: \_\_\_\_\_  
10. Driver's License Type: \_\_\_\_\_  
11. Driver's License Grade: \_\_\_\_\_  
12. Driver's License Level: \_\_\_\_\_  
13. Driver's License Class: \_\_\_\_\_  
14. Driver's License Category: \_\_\_\_\_  
15. Driver's License Endorsement: \_\_\_\_\_  
16. Driver's License Restriction: \_\_\_\_\_  
17. Driver's License Status: \_\_\_\_\_  
18. Driver's License Type: \_\_\_\_\_  
19. Driver's License Grade: \_\_\_\_\_  
20. Driver's License Level: \_\_\_\_\_

**PRIVACY ACT STATEMENT:** This statement is provided pursuant to the Privacy Act of 1974, 5 USC 552a.

**AUTHORITY:** The 49, United States Code (USC) 49 USC 31133(a)(8) and 31149(c)(1)(B).

**PURPOSE:** To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41, 49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41, 49. To record results of a driver's physical examination and to determine qualification to operate a CMV in interstate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41, 49 and any variances from the physical qualification standards adopted by such State.

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA, or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made (49 CFR 391.43(f)).

**ROUTINE USES:** The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Preliminary Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Preliminary Statement of General Routine Uses" (available at <http://www.dot.gov/privacy/privacyact/notice>).

**ACKNOWLEDGMENT:** I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.

Driver's Signature: \_\_\_\_\_  
Date: 10/05/16

**MEDICAL RECORD #** 205066 (or sticker)

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

**PERSONAL INFORMATION**

Last Name: Cousino First Name: Timothy Middle Initial: A Date of Birth: 03/02/81 Age: 35

Street Address: 2029 E. State rd. #31 City: Port Clinton Issuing State/Province: OH Phone: (419) 3411764 Gender: ☒ M ☐ F

Driver's License Number: Rq864959 CLP/CDL Applicant/Holder: ☒ Yes ☐ No

Driver ID Verified By: Driver's License

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 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.

(Attach additional sheets if necessary)

Last Name: Cousino

First Name: Timothy

Middle Initial: A

DOB: 03/02/81

Exam Date: 10/05/16

## DRIVER HEALTH HISTORY (continued)

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

Other health condition(s) not described above:

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below.

☒ Yes  
☐ No  
☐ Not Sure

## 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: 10/05/16

## 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).

Driver denies any medical conditions

(Attach additional sheets if necessary)

Last Name: Cousino First Name: Timothy Middle Initial: A DOB: 03/02/81 Exam Date: 10/05/16

TESTING

Pulse rate: 78 Pulse rhythm regular: ☒ Yes ☐ No Height: 6 feet 3 inches Weight: 235 pounds

Blood Pressure		Urinalysis	
Systolic	Diastolic	Sp. Gr.	Sugar
138	80	1.025	negative

Second reading (optional)

Other testing if indicated

Counselled to follow up with PCP for trace of hematuria and proteinuria

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**  
Right Eye: 20/25 Left Eye: 20/30  
Right Eye: 20/20 Left Eye: 20/20

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 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☒ Neither

**Whisper Test Results**  
Record distance (in feet) from driver at which a forced whispered voice can first be heard

Whisper Test Results		Audiometric Test Results	
Right Ear	Left Ear	Right Ear	Left Ear
5	5	500 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		Body System	
Normal	Abnormal	Normal	Abnormal
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1. General		8. Abdomen	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Skin		9. Genito-urinary system including hernias	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Eyes		10. Back/Spine	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Ears		11. Extremities/joints	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Mouth/throat		12. Neurological system including reflexes	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Cardiovascular		13. Gait	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Lungs/chest		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.

(Attach additional sheets if necessary)

Last Name: Cousins First Name: Timothy Middle Initial: A DOB: 03/02/81 Exam Date: 10/05/16

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 valuer/exemption (specify type):

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)

☐ 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: \_\_\_\_\_

☐ 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): Michael Platz

Medical Examiner's Address: 25660 Dixie Highway

City: Perrysburg

State: OH

Zip Code: 43561

Medical Examiner's Telephone Number: (419) 872-5343

Date Certificate Signed: 10/05/16

Medical Examiner's State License, Certificate, or Registration Number: 36 076936

Issuing State: OH

☒ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner (specify):

National Registry Number: 2191057327

Medical Examiner's Certificate Expiration Date: 10/05/18

Driver's Signature \_\_\_\_\_  
Driver's Address: 2029 E. State rd. #31  
City: Port Clinton  
State/Province: OH  
Zip Code: 43452  
CLP/CDL Applicant/Holder: \_\_\_\_\_  
Issuing State/Province: OH  
Driver's License Number: Rq864859

Medical Examiner's Signature: \_\_\_\_\_  
Medical Examiner's Name (please print or type): Michael Platz  
Medical Examiner's State License, Certificate, or Registration Number: 35.076936  
Issuing State: OH  
National Registry Number: 2191057327  
Medical Examiner's Telephone Number: (419) 872-5343  
Date Certificate Signed: 10/05/18

I certify that I have examined \_\_\_\_\_ Last Name: Cousino  
First Name: Timothy  
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, 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 interstate operations), and, with knowledge of the driving duties, find this person is qualified, and, if applicable, only when (check all that apply):  
☐ Wearing corrective lenses  
☐ Accompanied by a \_\_\_\_\_  
☐ Waiver/exemption  
☐ 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.  
Medical Examiner's Certificate Expiration Date: 10/05/18

Medical Examiner's Certificate