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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

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

MEDICAL RECORD #

____

(or sticker)

AUTHORITY: Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

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 intrastate 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(i)].

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) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses'' (available at http://www.dot.gov/privacy/privacyactnotices).

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

Driver's Signature: ______________________________ Date: ______________

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SECCIÓN 1. Información del conductor *(para ser llenada por el conductor)*

INFORMACIÓN PERSONAL

Apellido: ____________ Nombre: ____________ Inicial 2do. Nombre: ____ Fecha de Nac.: ____________ Edad: ______

Dirección: ____________________ Ciudad: ____________ Estado: ____________ Código Postal: ________

Licencia de Manejar No.: ____________________ Estado Emisor: ____________ Tel.: ____________ Sexo: ◯ M ◯ F

E-mail *(opcional)*: ______________________________ CLP/CDL Solicitante: ◯ Yes ◯ No

Driver ID Verified By**: ______________________________

Su certificado médico USDOT/FMCSA ha sido negado o emitido hace menos de 2 años? ◯ Si ◯ No ◯ No estoy seguro

*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.

HISTORIA MÉDICA DEL CONDUCTOR

Ha tenido alguna cirugía? Si ha tenido, por favor explique abajo. ◯ **Si** ◯ **No** ◯ **Inseguro**

Está usted tomando medicamentos *(prescritos, sin receta, remedios de hierbas, suplementos dietéticos)*? Si está tomando por favor explique abajo. ◯ **Si** ◯ **No** ◯ **Inseguro**

(Adjunte hojas adicionales si es necesario)

Apellido: ____________________ Nombre: _________________Inicial 2do. Nombre: ______ Fecha de Nac.: ____________ Fecha de Examen: ___________

HISTORIA MÉDICA *(continuación)*

Tiene o ha tenido:	Si	No	No Seguro
1. Lastimaduras/enfermedades de la cabeza *(como concusión)*	◯	◯	◯
2. Convulsiones, epilepsia	◯	◯	◯
3. Problemas de ojos *(excepto lentes o lentes de contacto)*	◯	◯	◯
4. Problemas del oído o audición	◯	◯	◯
5. Enfermedadades del corazón, ataque al corazón, "bypass", u otros problemas del corazón	◯	◯	◯
6. Marcapasos, "stents", dispositivos implantables, u otros procedimientos del corazón	◯	◯	◯
7. Presión alta	◯	◯	◯
8. Colesterol elevado	◯	◯	◯
9. Tos crónica (largo plazo), dificultad para respirar, u otros problemas de la respiración	◯	◯	◯
10. Enfermedades de los pulmones *(como asma)*	◯	◯	◯
11. Problemas de los riñones, piedras en los riñones, o dolor/problemas para orinar	◯	◯	◯
12. Estómago, hígado, o problemas digestivos	◯	◯	◯
13. Diabetes o problemas de azúcar en la	◯	◯	◯
sangre, uso de Insulina	◯	◯	◯
14. Ansiedad, depresión, nerviosismo, otros problemas mentales	◯	◯	◯
15. Desmayos	◯	◯	◯
16. Mareos, dolores de cabeza, entumecimiento, hormigueo, o pérdida de la memoria	◯	◯	◯
17. Pérdida inexplicable de peso	◯	◯	◯
18. Derrame cerebral, parálisis, o debilidad	◯	◯	◯
19. Falta o uso limitado del brazo, mano, pierna, pie, dedo	◯	◯	◯
20. Problemas del cuello o espalda	◯	◯	◯
21. Problemas de huesos, músculos, coyunturas o nervios	◯	◯	◯
22. Coágulos en la sangre o problemas de sangrado	◯	◯	◯
23. Cáncer	◯	◯	◯
24. Infecciones o enfermedades crónicas (largo plazo)	◯	◯	◯
25. Problemas de sueño, paro respiratorio al dormir, somnolencia durante el día, ronquidos	◯	◯	◯
26. Ha tenido prueba del sueño *(por apnea del sueño)*?	◯	◯	◯
27. Ha estado en el hospital por la noche?	◯	◯	◯
28. Se ha roto algún hueso?	◯	◯	◯
29. Fuma o ha fumado tabaco?	◯	◯	◯
30. Toma alcohol?	◯	◯	◯
31. Ha usado alguna substancia ilegal durante los últimos dos años?	◯	◯	◯
32. Ha fallado en un test de drogas o ha estado dependiente en el uso de una droga ilegal?	◯	◯	◯

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Alguna(s) otra(s) condición(es) de salud no descrita(s) arriba: ◯ **Si** ◯ **No** ◯ **Inseguro**

Respondió "si" a alguna de las preguntas 1-32? Si es así, por favor comente sobre esas condiciones de salud abajo. ◯ **Si** ◯ **No** ◯ **Inseguro**

(Adjunte hojas adicionales si es necesario)

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).

(Attach additional sheets if necessary)