

What does the DOT driver fill out (.doc)

Tops of every page with you name, date of birth: and examination date

Page 1

Page 2 up unto section 2.

DO NOT FILL OUT SECTION 2

Medical examiner's Certificate – bottom 2 lines only.

DO NOT FILL OUT THE REMAINDER OF THE CERTIFICATE

DO NOT FILL OUT

Page 3,4,5,6,

Last page: release of examination to your employer:

fill out if you do or don't want your employer to be able to have a copy of your dot examination.

Thank you.

Bradley H. Kline, D.O.


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.



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

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

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)? If "yes," please describe below. ☐ Yes ☐ No ☐ Not Sure

(Attach additional sheets if necessary)

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

Other health condition(s) not described above: ☐ Yes ☐ No ☐ Not Sure

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

(Attach additional sheets if necessary)

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).

(Attach additional sheets if necessary)

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)

Other testing if indicated

Urinalysis

Sp. Gr.

Protein

Blood

Sugar

Urinalysis is required.
Numerical readings
must be recorded.

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/____ | |

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?

Yes No

☐ ☐☐ ☐☐ ☐☐ ☐**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

Whisper Test Results

Right Ear Left Ear

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

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

Normal Abnormal

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

Body System

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

Normal Abnormal

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

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: _____ 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 ☐ 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: _____ 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): Bradley Kline DO

Medical Examiner's Address: 4105 US Highway #1, Suite #1 City: Monmouth Jct State: NJ Zip Code: 08852

Medical Examiner's Telephone Number: 908 227 6923 Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: 25MB04326600 Issuing State: NJ

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

☐ Other Practitioner (specify): _____

National Registry Number: 7370086174

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 variances

☐ 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 ☐ 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): Bradley Kline DO

Medical Examiner's Address: 4105 US Hwy #1, Suite #1 City: Moumouth Jct State: NJ Zip Code: 08852

Medical Examiner's Telephone Number: 908 227 6923 Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: 25MB04326600 Issuing State: NJ

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

☐ Other Practitioner (specify): _____

National Registry Number: 7370086174

Medical Examiner's Certificate Expiration Date: _____

Public Burden Statement

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

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 ☐ Accompanied by a _____ waiver/exemption

☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)

☐ Wearing hearing aid

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate

☐ Qualified by operation of 49 CFR 391.64 (Federal)

☐ Grandfathered from State requirements (State)

Medical Examiner's Certificate Expiration Date

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 Signature

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name (please print or type)

☐ MD

☐ Physician Assistant

☐ Advanced Practice Nurse

Bradley Kline DD

☒ DO

☐ Chiropractor

☐ Other Practitioner (specify) _____

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

Issuing State

National Registry Number

25M1304326600

NJ

7370086174

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

CLP/CDL Applicant/Holder

Street Address: _____

City: _____

State/Province: _____

Zip Code: _____

☐ Yes ☐ No

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Bradley H. Kline, D.O.

Telephone: 908 227 6923

e-mail: brad.h.kline@verizon.net

4105 U.S. Route One, Suite One, South Brunswick (Monm Junct) N.J., 08852

Date: _____

Pt name: _____

Date of Birth : _____

I (print your name) _____

[] Will allow

[] Will NOT allow

and permit my DOT examination preformed on: _____

To be sent to my employer: _____

At this address: _____

This fax number: _____

I want this authorization to expire on this date: _____

Signature: _____ Date: _____

Witness: _____