Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

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: LAURINCE First Name: JEAN Middle Initial: M Date of Birth: 09-04-1975 Age: 45

Street Address: 925 SW 6 PL City: Florida city State/Province: FL Zip Code: 33034

Driver's License Number: L652473753241 Issuing State/Province: 09-04 27 Phone: 786 738-396 Gender: ○ M ○ F

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

Blood preSure

(Attach additional sheets if necessary)