

Public Burden Statement

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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: FRASER First Name: Michael Middle Initial: D Date of Birth: 2/3/64 Age: 58
 Street Address: 11625 Cedar Crest Ave City: Allen Park State/Province: PA Zip Code: 19153
 Driver's License Number: 27570-993 Issuing State/Province: PA Phone: 415-951-3654
 E-Mail (optional): _____ CLPX/DL 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

*CLPX/DL Applicant/Holder: See instructions for definition.

*Driver ID Verified By: See instructions for definition. Type of photo ID 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

NO

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below.

☒ Yes ☐ No ☐ Not Sure

Fartiga 1000 2x1
 Rybelsus 700 1x
 lisinopril 40 2x
 carvedilol 25 1x

(Attach additional sheets if necessary)

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