



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 that does not display a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0008. Public reporting burden for this collection of information is estimated to be 15 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-488A, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

## Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: RejouisFirst Name: Harold

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  
☐ Wearing hearing aid

☐ Accompanied by a

waiver/exemption

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate

- ☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)  
☐ Qualified for operation of 49 CFR 391.61 (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 Signature

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name (please print or type)

- ☐ MD ☐ Physician Assistant  
☐ DO ☒ Chiropractor

- ☐ Advanced Practice Nurse  
☐ Other Practitioner (specify)

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

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

Street Address:

State/Province

Zip Code:

CLP/CDL Applicant/Holder

☒ Yes ☐ No

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