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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 #

PSH 0227

(for sticker)

SECTION 1. Driver Information (to be filled out by the driver)

PERSONAL INFORMATION

Last Name: BARANS First Name: GARY Middle Initial: _____ Date of Birth: 02/27/67 Age: _____
 Street Address: 236 WARELY CT City: Lexington State/Province: SC Zip Code: 29072
 Driver's License Number: 008733273 Issuing State/Province: SC Phone: 853
 E-Mail (optional): _____ CLP/CDL Applicant/Holder*: ☒ Yes ☐ No
 Driver ID Verified By*: Danielle Jermings
 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 definition.

**Driver ID verified by: Record what type of photo ID was used to verify the identity of the driver, e.g., DL, 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

Metformin 500 mg
 amlodipine 10 mg tablet
 Lisinopril 10 mg tablet

(Attach additional sheets if necessary)

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