* Form MCSA-5875

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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: Blocker First Name: Johnny Middle Initial: ___ Date of Birth: 01/12/74 Age: 49

Street Address: 6816 NW 15TH AVE City: Miami State/Province: FL Zip Code: 33147

Driver's License Number: B426-432-740-012-0 Issuing State/Province: Florida Phone: _____

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ⊘ Yes ○ No

Driver ID Verified By**: CDL

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)

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