

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 subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 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-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

A622

(or sticker)

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

PERSONAL INFORMATION

Last Name: ROBINSON First Name: JASON Middle Initial: E Date of Birth: 9-6-70 Age: 49
Street Address: 216 WESTVIEW ST City: LOS ANGELES State/Province: CA Zip Code: 90016
Driver's License Number: A6225327 Issuing State/Province: CA Phone: (323)9770274 Gender: M F
E-mail (optional): granddaddyjag@gmail CLP/CDL Applicant/Holder*: Yes No
Driver ID Verified By**: DL-CA
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)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: Robinson First Name: Jason DOB: 1/6/70 Exam Date: 7/31/20

DRIVER HEALTH HISTORY (continued)

Do you have or have you ever had:	Not				Not		
	Yes	No	Sure		Yes	No	Sure
1. Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems Insulin used	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
				31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Other health condition(s) not described above: Yes No Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. Yes No Not Sure

3. Cataract - resolved 28. Broken thumb - resolved
 9. Asthma - take albuterol as needed
 27. Accident - resolved 29, 30. Occasional drinking / smoking

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: [Signature] Date: 7/31/20

SECTION 2. Examination Report (to be filled out by the medical examiner)

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

Unremarkable

Further Discussion _____

(Attach additional sheets if necessary)

Last Name: ROBINSON First Name: JASON DOB: 9/6/1970 Exam Date: 7/31/2020

TESTING

Pulse rate: 77 Pulse rhythm regular: Yes No Height: 6 feet 2 inches Weight: 232 pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting	98	62	Urinalysis is required. Numerical readings must be recorded.	1.020	NEG	NEG	NEG
Second reading (optional)							

Other testing if indicated

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision
Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/ <u>40</u>	20/ <u>-</u>	Right Eye: <u>80</u> degrees
Left Eye:	20/ <u>25</u>	20/ <u>-</u>	Left Eye: <u>80</u> degrees
Both Eyes:	20/ <u>25</u>	20/ <u>-</u>	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors Yes No

Monocular vision Yes No

Referred to ophthalmologist or optometrist? Yes No

Received documentation from ophthalmologist or optometrist? Yes No

Hearing
Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test: Right Ear Left Ear Neither

Whisper Test Results
Record distance (in feet) from driver at which a forced whispered voice can first be heard

	Right Ear	Left Ear
	<u>6FT</u>	<u>6FT</u>

Audiometric Test Results

	Right Ear	Left Ear
500 Hz	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal
1000 Hz	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal
2000 Hz	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal	<input checked="" type="radio"/> Normal <input type="radio"/> Abnormal

Average (right): _____ Average (left): _____

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	<input checked="" type="radio"/>	<input type="radio"/>	8. Abdomen	<input checked="" type="radio"/>	<input type="radio"/>
2. Skin	<input checked="" type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input checked="" type="radio"/>	<input type="radio"/>
3. Eyes	<input checked="" type="radio"/>	<input type="radio"/>	10. Back/Spine	<input checked="" type="radio"/>	<input type="radio"/>
4. Ears	<input checked="" type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input checked="" type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input checked="" type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input checked="" type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input checked="" type="radio"/>	<input type="radio"/>	13. Gait	<input checked="" type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input checked="" type="radio"/>	<input type="radio"/>	14. Vascular system	<input checked="" type="radio"/>	<input type="radio"/>

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

UNREMARKABLE.

(Attach additional sheets if necessary)

Last Name: ROBINSON First Name: JASON DOB: 9/6/1970 Exam Date: 7/31/2020

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

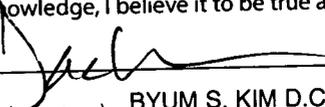
MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- Does not meet standards (specify reason): _____
- Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- Meets standards, but periodic monitoring required (specify reason): _____
 Driver qualified for: 3 months 6 months 1 year other (specify): _____
- Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____
- Accompanied by a Skill Performance Evaluation (SPE) Certificate Qualified by operation of 49 CFR 391.64 (Federal)
- Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- Determination pending (specify reason): _____
 Return to medical exam office for follow-up on (must be 45 days or less): _____
 Medical Examination Report amended (specify reason): _____
 (if amended) Medical Examiner's Signature: _____ Date: _____
- Incomplete examination (specify reason): _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: 

Medical Examiner's Name (please print or type): BYUM S. KIM D.C.

Medical Examiner's Address: 903 S. CRENSHAW BL #206A City: LOS ANGELES State: CA Zip Code: 90019

Medical Examiner's Telephone Number: 213-507-7530 Date Certificate Signed: 7/31/2020

Medical Examiner's State License, Certificate, or Registration Number: 30749 - CA Issuing State: CA

- MD DO Physician Assistant Chiropractor Advanced Practice Nurse
- Other Practitioner (specify): _____

National Registry Number: 7791444618

Medical Examiner's Certificate Expiration Date: 7/31/2022

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Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined **Last Name:** ROBINSON **First Name:** JASON 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 Accompanied by a _____ waiver/exemption

Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate

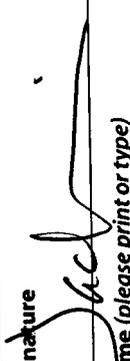
Driving within an exempt intracity zone (49 CFR 391.62) (Federal)

Qualified by operation of 49 CFR 391.64 (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 Certificate Expiration Date 7/31/2022

Medical Examiner's Signature 

Medical Examiner's Name (please print or type)
BYUM S. KIM D.C.

Medical Examiner's State License, Certificate, or Registration Number
30749 - CA

Medical Examiner's Telephone Number
213-507-7530

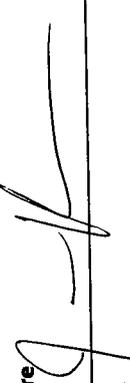
Date Certificate Signed
7/31/2020

MD Physician Assistant Advanced Practice Nurse

DO Chiropractor Other Practitioner (specify) _____

Issuing State
California

National Registry Number
7791444618

Driver's Signature 

Driver's License Number
A6225327

Issuing State/Province
California

State/Province: CA **Zip Code:** 90016 Yes No

City: LOS ANGELES **CLP/CDL Applicant/Holder**

Street Address: 2161 W VIEW ST APT 1

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