

Welcome to Medical Alliance of Southern New Jersey P.C.

Patient Information:

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone#: Home _____ Cell: _____ Work: _____

Email Address: _____

Date of Birth: _____ Sex: Male _____ Female _____ Race: _____

SS#: _____ Marital Status: _____

Work Status: _____ Name of Employer: _____

Emergency Contact & Phone #: _____

Primary Doctor Name & Phone#: _____

Referring Doctor Name & Phone#: _____

Reason for Visit:

Allergies:

(Please indicate any allergies to medications, dyes, foods, herbs, metals, latex or other substances.)

Health Maintenance:

(Please place a checkmark next to the items that you have had done in the past and the date)

<u>TEST</u>	<u>MOST RECENT DATE DONE</u>
Bone Density Scan	_____
Cholesterol	_____
Colonoscopy	_____
ECHO	_____
EKG	_____
Flu Immunization	_____
Hepatitis B Vaccine	_____
HgbA1C	_____
Mammogram	_____
Microalbumin	_____
Pneumovax Immunization	_____
PSA Test	_____
TSH	_____
Tuberculosis Test	_____
Urinalysis	_____
Stool for Occult Blood	_____

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)

PRIVACY ACT STATEMENT: This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.

AUTHORITY: Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

PURPOSE: To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State.

MEDICAL RECORD #

(or sticker)

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].

ROUTINE USES: The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses" (available at <http://www.dot.gov/privacy/privacyactnotices>).

ACKNOWLEDGMENT: I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.

Driver's Signature: _____ Date: _____

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

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____ Gender: M F

E-mail (optional): _____ CLP/CDL 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

*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)? Yes No Not Sure

If "yes," please describe below.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____ Exam Date: _____

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 type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems Insulin used	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input 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

(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: _____ Date: _____

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).

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____ Exam Date: _____

TESTING

Pulse rate: _____ Pulse rhythm regular: Yes No Height: ___ feet ___ inches Weight: ___ pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
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Sitting	Urinalysis is required. Numerical readings must be recorded.						
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/____	20/____	Right Eye: ___ degrees
Left Eye:	20/____	20/____	Left Eye: ___ degrees
Both Eyes:	20/____	20/____	

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 Right Ear Left Ear

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

Audiometric Test Results

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
_____	_____	_____	_____	_____	_____
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 type="radio"/>	<input type="radio"/>	8. Abdomen	<input type="radio"/>	<input type="radio"/>
2. Skin	<input type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input type="radio"/>	<input type="radio"/>
3. Eyes	<input type="radio"/>	<input type="radio"/>	10. Back/Spine	<input type="radio"/>	<input type="radio"/>
4. Ears	<input type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input type="radio"/>	<input type="radio"/>	13. Gait	<input type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input type="radio"/>	<input type="radio"/>	14. Vascular system	<input 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.

(Attach additional sheets if necessary)

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____ Exam Date: _____

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): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with 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):

Does not meet standards in 49 CFR 391.41 with any applicable State variances (specify reason): _____

Meets standards in 49 CFR 391.41 with any applicable State variances

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 Grandfathered from State requirements (State)

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, 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): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date: _____



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

Medical Examiner's Certificate
(for Commercial Driver Medical Certification)

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I certify that I have examined **Last Name:** _____ **First Name:** _____ 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 Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
 - Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate 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

Medical Examiner's Signature	Medical Examiner's Telephone Number	Date Certificate Signed
_____	_____	_____
Medical Examiner's Name (please print or type)	<input type="radio"/> MD <input type="radio"/> Physician Assistant <input type="radio"/> Advanced Practice Nurse <input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> 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: _____	City: _____
_____	State/Province: _____	Zip Code: _____
_____	<input type="radio"/> Yes <input type="radio"/> No	CLP/CDL Applicant/Holder