**CDL Medical Certificate Form**

**Driver Information:**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **CDL Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Please check the box if you have ever had or currently have any of the following conditions:

* **☐ Diabetes**
* **☐ Heart Disease**
* **☐ High Blood Pressure**
* **☐ Respiratory Problems**
* **☐ Digestive Issues**
* **☐ Neurological Disorders**
* **☐ Vision Problems**
* **☐ Hearing Problems**
* **☐ Mental Health Disorders**
* **☐ Alcohol or Drug Dependency**
* **☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications:**

Please list any medications you are currently taking:

**Physical Examination:**

Please check the box if the following conditions are met:

* **☐ Vision: 20/40 or better in each eye with or without correction**
* **☐ Hearing: Able to perceive a forced whisper at 5 feet or more**
* **☐ Blood Pressure: Below 140/90**
* **☐ Heart: No abnormal sounds or irregular rhythms**
* **☐ Lungs: Clear with no signs of respiratory issues**
* **☐ Abdomen: No abnormalities or tenderness**
* **☐ Musculoskeletal: Full range of motion, no abnormalities**
* **☐ Neurological: No abnormalities in reflexes or coordination**

**Additional Information:**

* Have you had any surgeries in the past year? ☐ Yes ☐ No If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Certification:**

I certify that the above information is true and accurate to the best of my knowledge.

**Driver's Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_