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:

_____

_____

_____

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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: _____

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