Medical Card Self-Certification Form

Personal Information

- **Full Name: _____**
- **Date of Birth (MM/DD/YYYY): _____**
- **Address: _____**
- **City: _____ State: _____ ZIP: _____**
- **Contact Number: _____**
- **Email Address: _____**

Driver's License Information

- **Driver's License Number: _____**
- **State of Issuance: _____**
- **CDL License Type: ☐ Class A ☐ Class B ☐ Class C**
- **License Expiration Date: _____**

Medical Certification

I hereby certify that I operate my commercial motor vehicle under the category checked below:

- **☐ Non-Excepted Interstate (I am required to meet medical certificate requirements under 49 CFR part 391)**
- **☐ Excepted Interstate (I am exempt from the medical certificate requirements)**
- **☐ Non-Excepted Intrastate (I am required to meet my state's medical certificate requirements)**
- **☐ Excepted Intrastate (I am exempt from my state's medical certificate requirements)**

Medical Examiner's Certificate Information (If Applicable)

- **Medical Examiner's Certificate Number: _____**
- **Date of Issuance: _____**
- **Certificate Expiration Date: _____**
- **Medical Examiner's Name: _____**
- **Medical Examiner's Phone Number: _____**

Self-Certification Statement

I, _____, certify that the information provided above is true and correct to the best of my knowledge. I understand that providing false information may result in penalties or suspension of my driving privileges.

Signature: _____

Date: _____

For Office Use Only

Verified By	Date Verified	Approved ☐ / Rejected ☐	Comments

Instructions for Submission

- **Please attach a copy of your Medical Examiner's Certificate (if applicable).**
- **Submit this form to the Department of Motor Vehicles or your state's licensing authority.**
- **Ensure all information is accurate to avoid delays in processing your certification.**