Dot Physical Certificate Form

Certificate Holder Details

Name: _____

Date of Birth: _____

Address: _____

Driver's License Number: _____

Medical Examination Details

- **Vision Test: _____**
- **Hearing Test: _____**
- **Blood Pressure: _____**
- **Height: _____ Weight: _____**

Health History

[ ] No Known Medical Conditions

[ ] Diabetes

[ ] High Blood Pressure

[ ] Other: _____

Certification Results

[ ] Fully Certified for DOT Operations

[ ] Certified with Restrictions: _____

[ ] Disqualified (reason): _____

Examining Medical Professional

Name: _____

License Number: _____

Signature: _____ Date: _____