Dot Physical Form PA

Driver Information

Full Name: ________________________________

Date of Birth: _____________________________

Address: ________________________________

Driver's License Number: _____________________________

State of Issue: _____________________________

Medical Examiner Information

Name: ________________________________

License Number: _____________________________

Clinic Name: ________________________________

Contact Number: _____________________________

Physical Examination Details

Test Category	Test Result	Pass/Fail	Notes
Vision Test		[ ] Pass [ ] Fail	
Hearing Test		[ ] Pass [ ] Fail	
Blood Pressure		[ ] Pass [ ] Fail	
Height and Weight		[ ] Pass [ ] Fail	

Medical Certification

[ ] Qualified for DOT driving.

[ ] Temporarily Disqualified (reason): ________________________________

[ ] Requires Further Testing.

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Signatures

Medical Examiner: ______________________ Date: ___________________

Driver: ________________________________ Date: ___________________

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