



Physical Examination

(VALID FOR NOT MORE THAN TWO YEARS FROM DATE OF EXAM)

After August 1, 2012, new examinations must provide a US Department of Transportation Medical Examiner's Certificate, completed within the past 90 days by an examiner meeting the US Department of Transportation standards under 49 CFR 391.41 - 391.49.

PLEASE PRINT

DRIVER'S NAME	<i>Last</i>	<i>First</i>	<i>Middle</i>	(AREA CODE) TELEPHONE NUMBER	
STREET ADDRESS			CITY	STATE	DATE OF BIRTH

TO BE COMPLETED BY MEDICAL EXAMINER *(Please Print)*

Answer each question yes or no where appropriate. The medical examiner should be aware of the rigorous physical demands and mental and emotional responsibilities placed on the driver of a limousine vehicle. In the interest of public safety the medical examiner is required to certify that the driver does not have any physical, mental, or organic defect of such a nature as to affect the driver's ability to operate a limousine vehicle.

Health History:

Height: _____ ft. _____ in.

Weight: _____ lbs.

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> <td style="width: 90%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Psychiatric disorder</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Cardiovascular disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Head or spinal injuries</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Seizures, fits, convulsions, or fainting</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Any other nervous disorder</td> </tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, or fainting	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> <td style="width: 90%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Muscular disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Rheumatic fever</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Asthma</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Kidney disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Tuberculosis</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Gastrointestinal ulcer</td> </tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal ulcer	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> <td style="width: 90%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Nervous stomach</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Syphilis</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Gonorrhea</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Extensive confinement by illness or injury</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Suffering from any other disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Permanent defect from illness, disease or injury</td> </tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disease	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease or injury
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If the answer to any of the above is yes, explain in General Comments section below.

General appearance and development: Good _____ Fair _____ Poor _____

Vision: For distance: Right 20/ _____ Left 20/ _____ Without corrective lenses With corrective lenses, if worn

Horizontal field of vision: Right _____ Left _____

Evidence of disease or injury: Right _____ Left _____

Color test _____

Hearing: Right ear _____ Left ear _____

Disease or injury _____

Audiometric test: *(If audiometer is used to test hearing)* Decibel loss at 500 Hz _____ at 1,000 Hz _____ at 2,000 Hz _____

Throat: _____

Thorax: Heart _____

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after exercise _____

Lungs: _____

Abdomen: Scars _____ Abnormal masses _____ Tenderness _____

Hernia: Yes No If so, where? _____ Is truss worn? _____

Gastrointestinal: Ulceration or other disease _____

Genito-Urinary: Scars _____

Reflexes: Romberg _____

Pupillary _____ Light Right _____ Left _____

Accommodation: Right _____ Left _____

Knee Jerks: Right: Normal _____ Increased _____ Absent _____

Left: Normal _____ Increased _____ Absent _____

Extremities: Upper _____ Lower _____ Spine _____

Laboratory and other Urine: Spec. Gr. _____ Alb. _____ Sugar _____

Other laboratory data (Serology, etc.) _____

special findings: Radiological data _____ Electrocardiograph _____

General Comments: _____

Check here if NOT qualified

Medical Examiner _____ License/Cert. No. & State _____

PRINT NAME & TITLE

Address _____

Medical Examiner **X** _____ Date of Examination _____

SIGNATURE MUST APPEAR HERE