# Missouri Skill Performance Evaluation Certificates

For Intrastate Drivers

**Missouri allows individuals to apply for a Skill Performance Evaluation certificate if they are not physically qualified to drive commercial motor vehicles intrastate because of one or more of the following conditions:**

- Limb amputation
- Limb impairment
- Vision impairment
- Insulin-treated diabetes mellitus

**If the application is approved, the driver is authorized to haul in intrastate commerce – that is, the vehicle and its load must originate and end within Missouri's borders only.**

**Is the Missouri SPE certificate the same as the federal SPE certificate?**
No. The Missouri certificate qualifies drivers to operate only within Missouri's borders.

The federal SPE certificate program is for interstate drivers and applies only to limb-impaired and amputee drivers.
Drivers with a vision impairment or diabetes can apply for a federal medical exemption to operate interstate.

**Can I apply for an SPE certificate on my own or do I need a sponsor?**
Applications can be filed by an individual driver or jointly by the driver and a sponsoring employer.

**What is involved in the SPE process?**
Applicants must complete an application and provide required documents. In limb-impaired/amputation cases, a skill evaluation must be performed. Vision and diabetes exemptions are submitted for public comment before a decision is made.

**I already have a federal SPE certificate or medical exemption. Now I want to drive in Missouri only. Can I?**
You must apply for a Missouri SPE certificate, but some application requirements can be waived if your federal certificate or exemption is still valid.

**How long does the Missouri SPE certificate application process take?**
Once your completed application is received, the process is normally complete within six months. However, the process could take longer if any application details or documents are missing or if scheduling issues delay a skill evaluation (when applicable).

**What supporting documents are required with the application?**
The documents needed vary with each disabling condition. If you are not physically qualified because of two or more of the conditions listed above, submit the required documentation relating to each condition.
Most forms are available for download at www.modot.org/mcs under Safety & Compliance Exceptions include forms provided by other agencies, such as a motor vehicle driving record or a federal SPE certificate.

**NOTE**: *MoDOT is neither responsible for selecting the medical specialist(s) needed to complete the application, providing the vehicle for a skill evaluation nor for any expenses incurred. These are the applicant's responsibility.*

(See the next page for a list of supporting documents.)

**ALL APPLICATIONS**

The following documents must be completed and submitted with every application for a SPE Certificate:

- ☑ Statement of Treating Physician (**SPEC-B FORM**)
- ☑ Waiver or Privacy Regarding Personal Health Information (**SPEC-C FORM**)
- ☑ HIPAA Compliant Authorization for Release of Information
- ☑ Physical Examination Form and Medical Examiner's Certificate Form
- ☑ Road Test and Road Test Certification Form. A motor carrier or a person who is competent to administer the test and evaluate its results must administer the road test.
- ☑ Driver Employment Application Form. This form is provided for your use if you do not have a copy of the last one you completed for your last employer.
- ☑ Copy of State motor vehicle driving record (MVR) for the past 3 years from each State in which you held a driver's license or permit. * *Available through the Missouri Department of Revenue*
- ☑ Copy of your interstate SPE certificate, exemption or waiver of certain physical defects issued by FMCSA or the individual State(s), if applicable. **Available from the FMCSA and/or other states*

**LIMB IMPAIRMENT OR AMPUTATION FORMS**

A board-certified or board-eligible orthopedic surgeon, doctor of physical medicine or physiatrist must complete the Medical Evaluation Summary. Although you may choose any qualified medical specialist, we recommend that you go to a physical rehabilitation facility for this examination. These facilities and their personnel generally have more experience in evaluating the amputee or a limb-impaired individual.

- ☐ Application for Skill Performance Evaluation Certificate to Operate Intrastate Commercial Motor Vehicles (Applicant with Limb Impairment or Amputation) (**SPEC-1 FORM**)
- ☐ Medical Evaluation Summary (**SPEC-A FORM**) (Limb Impairment or Amputation Only)

**VISION IMPAIRMENT**

- ☐ Application for Skill Performance Evaluation (SPE) Certificate to Operate Intrastate Commercial Motor Vehicles (Applicant with Impaired Vision) (**SPEC-2 FORM**)
- ☐ Optometrist/Ophthalmologist Certification (**SPEC-D FORM**)
- ☐ Affidavit of Driving Experience (**SPEC-E FORM**)

**INSULIN-TREATED DIABETES MELLITUS.**

- ☐ Application for Skill Performance Evaluation (SPE) Certificate to Operate Intrastate Commercial Motor Vehicles (Applicant with Insulin-Treated Diabetes Mellitus (ITDM)) (**SPEC-3 FORM**)
- ☐ Optometrist/Ophthalmologist Certification (**SPEC-D FORM**)
- ☐ Affidavit of Driving Experience (**SPEC-E FORM**)
- ☐ Endocrinologist Certification (**SPEC-F FORM**)

**Questions?** Contact the MoDOT Motor Carrier Services Safety and Compliance team.
Call toll-free, 1- 866-831-6277.

Return completed application and supporting documents to:
**ATTN: MEDICAL EXEMPTION PROGRAM**
MoDOT Motor Carrier Services
P.O. Box 270
Jefferson City, MO 65102-0270

# SPEC-B FORM

**(Statement of Treating Physician, Required by RSMo 622.555)**

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

## STATEMENT OF TREATING PHYSICIAN, FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

| **MAIL COMPLETED FORM TO:** | ATTN: MEDICAL EXEMPTION PROGRAM<br>MOTOR CARRIER SERVICES<br>PO BOX 270<br>JEFFERSON CITY, MO 65102-0270 | IF ASSISTANCE NEEDED, CALL:<br>573-522-4937 OR Toll Free at 866-831-6277<br>FAX 573-522-4260 |
|---|---|---|

**SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT (To be completed by driver applicant).**

| | | | |
|---|---|---|---|
| DRIVER-APPLICANT'S FULL NAME | | | |
| RESIDENCE ADDRESS | | | GENDER (Please check one box) ☐MALE ☐FEMALE |
| CITY | STATE | ZIP | DATE OF BIRTH |
| (AREA CODE) HOME TELEPHONE #<br>( ) | (AREA CODE) WORK PHONE # (IF ANY)<br>( ) | SOCIAL SECURITY # | |
| DRIVER'S LICENSE # | STATE WHICH ISSUED | DATE ISSUED | EXPIRATION DATE |

**SECTION 2. IDENTIFICATION OF TREATING PHYSICIAN**

| | | |
|---|---|---|
| TREATING PHYSICIAN'S BUSINESS NAME | | BOARD CERTIFIED<br>☐ YES ☐ NO |
| TREATING PHYSICIAN'S FULL NAME | | BOARD ELIGIBLE<br>☐ YES ☐ NO |
| BUSINESS ADDRESS | | |
| CITY | STATE | ZIP |
| (AREA CODE) OFFICE TELEPHONE #<br>( ) | (AREA CODE) OFFICE FAX #<br>( ) | PROFESSIONAL CERTIFICATION # |
| NAME OF CERTIFYING ORGANIZATION | | PROFESSIONAL LICENSE # |
| ADDRESS OF CERTIFYING ORGANIZATION | | |
| CITY | STATE | ZIP |

**SECTION 3. TO BE COMPLETED BY TREATING PHYSICIAN**

| | |
|---|---|
| A ☐ | PLEASE GIVE A BRIEF DESCRIPTION OF THE APPLICANT'S MEDICAL CONDITION FOR WHICH A SKILL PERFORMANCE EVALUATION CERTIFICATE IS NECESSARY.<br>←CHECK BOX TO CONFIRM COMPLETION. |
| | |
| | |
| | |
| B ☐ | IS THE PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH ACTUAL TREATMENT?<br>←CHECK BOX TO CONFIRM COMPLETION. |

| | | |
|---|---|---|
| ☐ YES - HOW LONG? | | ☐ NO - EXPLAIN: |
| | | |
| | | |
| | | |

***NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.***

## SECTION 3. TO BE COMPLETED BY TREATING PHYSICIAN *(Continued)*

C ☐ IS THE TREATING PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH CONSULTATION WITH ANOTHER PHYSICIAN WHO HAS TREATED THE APPLICANT?

| ☐ YES | PHYSICIAN'S NAME | BUSINESS ADDRESS | | |
|---|---|---|---|---|
| CITY | | STATE | ZIP | (AREA CODE) BUSINESS TELEPHONE # ( ) |

☐ NO - EXPLAIN:

D ☐ DOES THE APPLICANT HAVE THE ABILITY AND WILLINGNESS TO FOLLOW ANY COURSE OF TREATMENT PRESCRIBED, INCLUDING THE ABILITY TO SELF-MONITOR OR MANAGE THE MEDICAL CONDITION?

☐ YES ☐ NO - EXPLAIN:

E ☐ IN YOUR PROFESSIONAL OPINION, WILL THE APPLICANT'S CONDITION ADVERSELY AFFECT HIS/HER ABILITY TO OPERATE A COMMERCIAL MOTOR VEHICLE SAFELY?

☐ YES ☐ NO - EXPLAIN:

F ☐ IN YOUR PROFESSIONAL OPINION, WILL THE APPLICANT'S CONDITION LIKELY REMAIN STABLE OVER THE LIFETIME OF THE DRIVER-APPLICANT?

☐ YES ☐ NO - EXPLAIN:

## SECTION 4. TREATING PHYSICIANS CERTIFICATION AND VERIFICATION

**I FURTHER DECLARE UNDER PENALTY OF PERJURY** UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION, AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

| TREATING PHYSICIAN'S NAME (Printed) | DATE SIGNED: |
|---|---|
| TREATING PHYSICIAN'S SIGNATURE | |

*NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.*

**SPEC-C FORM** (WAIVER OF PRIVACY)

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

# WAIVER OF PRIVACY REGARDING PERSONAL HEALTH INFORMATION

| | |
|---|---|
| ATTN: MEDICAL EXEMPTION PROGRAM<br>MOTOR CARRIER SERVICES<br>PO BOX 270<br>JEFFERSON CITY, MO 65102-0270 | IF ASSISTANCE NEEDED, CALL:<br>573-522-4937 OR Toll Free at 866-831-6277<br>FAX 573-522-4260 |

THE UNDERSIGNED APPLICANT FOR A SKILL PERFORMANCE EVALUATION CERTIFICATE ACKNOWLEDGES THAT HE/SHE HAS READ AND UNDERSTOOD THE FOLLOWING WAIVER OF PRIVACY, AND HEREBY CONSENTS TO ALL PROVISIONS STATED BELOW.

Missouri law generally requires that all records possessed by state agencies shall be open to public inspection and copying. Laws governing the motor carrier transportation activities of the Missouri Highways and Transportation Commission (MHTC), and the Missouri Department of Transportation (MoDOT), also provide that documents filed on the record in formal proceedings of the commission or department shall be public records, and open to public inspection and copying. These laws govern all applications, and related materials and information, which are submitted to MoDOT Motor Carrier Services, which seek the issuance of Skill Performance Evaluation (SPE) Certificates.

By signing and submitting the application and related materials and information to MoDOT Motor Carrier Services, I, THE UNDERSIGNED APPLICANT, VOLUNTARILY WAIVE MY RIGHT TO PRIVACY with reference to these application materials and all related information. I authorize MHTC, MoDOT, their officers and personnel, to make all reasonable and necessary uses of the information submitted in connection with this application, whether submitted by me personally, by physicians, doctors, nurses, health care providers, or any other person. This waiver includes, but is not limited to, authorizing public disclosure of such information whenever, and to the extent that, MHTC or MoDOT considers such disclosure to be reasonable or necessary in furtherance of the administration of the Skill Performance Evaluation Certificate program. I understand and agree that this may, if required, include publication of one or more notices of the filing and determination of my application, which may describe my physical condition, impairment, health history, etc., and may invite public comments relating to my application and physical condition. I understand that any comments received may also be published.

I also agree that MHTC and MoDOT personnel may transmit any and all information to officials of any other Federal and State agencies, for purposes relating to the administration of this program, or similar programs administered by those governmental entities.

With reference to all information coming into the possession, custody or control of MHTC or MoDOT pursuant to this application, this waiver of privacy shall be continuing, including after the conclusion of the application proceedings.

Dated:_____ Applicant Signature:_____

The above form has been approved by the Director of Motor Carrier Services, for use in relation to the Skill Performance Evaluation (SPE) Certificate program administered by MoDOT Motor Carrier Services. (version 06/07/16)

# HIPAA-COMPLIANT
# AUTHORIZATION FOR RELEASE OF INFORMATION
# PURSUANT TO 45 C.F.R. 164.508

**Patient Name:** _____ Date of Birth: _____

**Provider/Covered Entity:** (Organizations, individuals, or classes of persons requested to disclose patient information)

***(To be completed by Motor Carrier Services:)***

*Name:* _____

*Address:* _____

_____

**Requestors:** (To whom the provider/covered entity is requested to disclose patient information):

Missouri Highways and Transportation Commission, and/or
Missouri Department of Transportation, Motor Carrier Services Division.
ATTN: Medical Exemption Program—Motor Carrier Services
PO Box 270
Jefferson City, MO 65102-0270
TEL: (573) 522-9001; FAX: (573) 522-4260

**Information Requested:** The Patient identified above authorizes the disclosure of all protected medical information in any form (including oral, written and electronic) to the Requestors listed above, and Requestors' re-disclosure of the data and information to its agents, consultants, counsel, and whomever Requestors deems reasonable and necessary to further the administration of the Skill Performance Evaluation Certification program. Patient expressly requests that all covered entities under HIPAA identified above shall disclose full and complete protected health information concerning the Patient, relating to the time period beginning on _____ and ending on _____, inclusive. This includes, but is not limited to, the following:

- All medical records, including, but not limited to: inpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, examination reports, office and doctor's handwritten notes, and records received from other physicians or health care providers;
- All laboratory, histology, cystology, pathology, radiology, CT scan, MRI, echocardiogram reports;
- All radiology films;
- All pharmacy prescription records.

**Purposes of Release:** Release of this information is requested for the purposes of evaluating, reviewing, and monitoring the patient's qualifications to operate commercial motor vehicles safely, in connection with the patient's application for issuance of a Skill Performance Evaluation Certificate by the Missouri Department of Transportation, Motor Carrier Services Division.

This authorization is effective until the later of _____, or the date when my application for issuance of a Skill Performance Evaluation Certificate is finally determined, or (if the application is granted) the date when my SPE Certificate expires.

I understand that I may revoke this authorization at any time, by giving written notice to the Missouri Department of Transportation, Motor Carrier Services Division, at the address mentioned above. I understand that revocation is only effective after the written notice is received by MoDOT Motor Carrier Services Division, and that any use or disclosure of the information under this authorization, made before the revocation is effective, will not be affected by the revocation.

I understand that I am entitled to receive a copy of this authorization.

I understand that, after information is released under this authorization, it may be re-disclosed by the recipient, and if re-disclosed, the information will no longer be protected by federal or state privacy rules.

I understand that the covered entity to which this authorization is directed may not condition treatment, payment, enrollment, or eligibility benefits on whether or not I sign this authorization.

Any facsimile, copy or photocopy of the authorization authorizes the release of all records requested herein.

**Signature of Patient:** _____ **Date:** _____

In addition to the authorization and other provisions contained above, hereby incorporated by reference, I authorize the release of mental health records (includes psychological testing) to Requestors and re-disclosure of the data and information to their agents, counsel or whomever Requestors deems reasonable and necessary to further the administration of my Skill Performance Evaluation Certificate application. This includes any and all data, notes, records, reports and information protected by state and federal law.

**Signature of Patient:** _____ **Date:** _____

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

# Medical Examination Report Form
(for Commercial Driver Medical Certification)

**PRIVACY ACT STATEMENT:** ***This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.***

**MEDICAL RECORD #**

_____

*(or sticker)*

**AUTHORITY:** Title 49, United States Code (USC), 49 USC 31133(a)(8) and 31149(c)(1)(E).

**PURPOSE:** To record results of a driver's physical examination, to determine qualification to operate a commercial motor vehicle (CMV), and to promote driver health in interstate commerce according to the requirements in 49 CFR 391.41-49. Providing this information is mandatory. If this information is not provided, the medical examiner will not be able to determine qualification to operate a CMV in interstate commerce according to the requirements in 49 CFR 391.41-49. To record results of a driver's physical examination and to determine qualification to operate a CMV in intrastate commerce when the driver is required by a State to be examined by a medical examiner listed on the National Registry of Certified Medical Examiners in accordance with the provisions of 49 CFR 391.41-49 and any variances from the physical qualification standards adopted by such State.

Medical examiners are required to complete the Medical Examination Report Form for every driver physical examination performed in accordance with 49 CFR 391.41. Each original (paper or electronic) completed Medical Examination Report Form must be retained on file at the office of the medical examiner for at least 3 years from the date of examination. The medical examiner must make all records and information in these files available to an authorized representative of FMCSA or an authorized Federal, State, or local enforcement agency representative, within 48 hours after the request is made [49 CFR 391.43(i)].

**ROUTINE USES:** The information is used for the purpose set forth above and may be forwarded to Federal, State, or local law enforcement agencies for their use. Medical Examination Report Forms collected by FMCSA will be stored in FMCSA's automated National Registry of Certified Medical Examiners System and will be used to monitor the performance of medical examiners listed on the National Registry.

In addition to those disclosures permitted under 5 USC 552a(b) of the Privacy Act of 1974, additional disclosures may be made in accordance with the U.S. Department of Transportation (DOT) Prefatory Statement of General Routine Uses published in the Federal Register on December 29, 2010 (75 FR 82132), under "Prefatory Statement of General Routine Uses" (available at http://www.dot.gov/privacy/privacyactnotices).

**ACKNOWLEDGMENT:** ***I understand the provisions of the Privacy Act of 1974 as related to me through the above-mentioned statement.***

Driver's Signature: _____ Date: _____

## SECTION 1. Driver Information *(to be filled out by the driver)*

### PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____ Gender: ◯ M ◯ F

E-mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ◯ Yes ◯ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ◯ Yes ◯ No ◯ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

### DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

*(Attach additional sheets if necessary)*

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

## DRIVER HEALTH HISTORY *(continued)*

| Do you have or have you ever had: | Yes | No | Not Sure |
|---|---|---|---|
| 1. Head/brain injuries or illnesses *(e.g., concussion)* | ○ | ○ | ○ |
| 2. Seizures, epilepsy | ○ | ○ | ○ |
| 3. Eye problems *(except glasses or contacts)* | ○ | ○ | ○ |
| 4. Ear and/or hearing problems | ○ | ○ | ○ |
| 5. Heart disease, heart attack, bypass, or other heart problems | ○ | ○ | ○ |
| 6. Pacemaker, stents, implantable devices, or other heart procedures | ○ | ○ | ○ |
| 7. High blood pressure | ○ | ○ | ○ |
| 8. High cholesterol | ○ | ○ | ○ |
| 9. Chronic (long-term) cough, shortness of breath, or other breathing problems | ○ | ○ | ○ |
| 10. Lung disease *(e.g., asthma)* | ○ | ○ | ○ |
| 11. Kidney problems, kidney stones, or pain/problems with urination | ○ | ○ | ○ |
| 12. Stomach, liver, or digestive problems | ○ | ○ | ○ |
| 13. Diabetes or blood sugar problems | ○ | ○ | ○ |
| Insulin used | ○ | ○ | ○ |
| 14. Anxiety, depression, nervousness, other mental health problems | ○ | ○ | ○ |
| 15. Fainting or passing out | ○ | ○ | ○ |
| 16. Dizziness, headaches, numbness, tingling, or memory loss | ○ | ○ | ○ |
| 17. Unexplained weight loss | ○ | ○ | ○ |
| 18. Stroke, mini-stroke (TIA), paralysis, or weakness | ○ | ○ | ○ |
| 19. Missing or limited use of arm, hand, finger, leg, foot, toe | ○ | ○ | ○ |
| 20. Neck or back problems | ○ | ○ | ○ |
| 21. Bone, muscle, joint, or nerve problems | ○ | ○ | ○ |
| 22. Blood clots or bleeding problems | ○ | ○ | ○ |
| 23. Cancer | ○ | ○ | ○ |
| 24. Chronic (long-term) infection or other chronic diseases | ○ | ○ | ○ |
| 25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring | ○ | ○ | ○ |
| 26. Have you ever had a sleep test *(e.g., sleep apnea)*? | ○ | ○ | ○ |
| 27. Have you ever spent a night in the hospital? | ○ | ○ | ○ |
| 28. Have you ever had a broken bone? | ○ | ○ | ○ |
| 29. Have you ever used or do you now use tobacco? | ○ | ○ | ○ |
| 30. Do you currently drink alcohol? | ○ | ○ | ○ |
| 31. Have you used an illegal substance within the past two years? | ○ | ○ | ○ |
| 32. Have you ever failed a drug test or been dependent on an illegal substance? | ○ | ○ | ○ |

Other health condition(s) not described above: ○ **Yes** ○ **No** ○ **Not Sure**

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ○ **Yes** ○ **No** ○ **Not Sure**

*(Attach additional sheets if necessary)*

## CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

**SECTION 2. Examination Report** *(to be filled out by the medical examiner)*

## DRIVER HEALTH HISTORY REVIEW

*Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).*

*(Attach additional sheets if necessary)*

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

## TESTING

Pulse rate: _____ Pulse rhythm regular: ◯ Yes ◯ No Height: __ *feet* __ *inches* Weight: ____ *pounds*

| **Blood Pressure** | Systolic | Diastolic |
|---|---|---|
| Sitting | | |
| Second reading (optional) | | |

| **Urinalysis** | Sp. Gr. | Protein | Blood | Sugar |
|---|---|---|---|---|
| Urinalysis is required. Numerical readings must be recorded. | | | | |

Other testing if indicated

*Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.*

### Vision

*Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.*

| **Acuity** | Uncorrected | Corrected | Horizontal Field of Vision |
|---|---|---|---|
| Right Eye: | 20/____ | 20/____ | Right Eye: ____ degrees |
| Left Eye: | 20/____ | 20/____ | Left Eye: ____ degrees |
| Both Eyes: | 20/____ | 20/____ | |

| | **Yes** | **No** |
|---|---|---|
| Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors | ◯ | ◯ |
| Monocular vision | ◯ | ◯ |
| Referred to ophthalmologist or optometrist? | ◯ | ◯ |
| Received documentation from ophthalmologist or optometrist? | ◯ | ◯ |

### Hearing

*Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ◯ Right Ear ◯ Left Ear ◯ Neither

| **Whisper Test Results** | Right Ear | Left Ear |
|---|---|---|
| Record distance *(in feet)* from driver at which a forced whispered voice can first be heard | _____ | _____ |

***OR***

**Audiometric Test Results**

| Right Ear | | | Left Ear | | |
|---|---|---|---|---|---|
| 500 Hz | 1000 Hz | 2000 Hz | 500 Hz | 1000 Hz | 2000 Hz |
| _____ | _____ | _____ | _____ | _____ | _____ |

Average (right): _____ Average (left): _____

## PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

| **Body System** | Normal | Abnormal | **Body System** | Normal | Abnormal |
|---|---|---|---|---|---|
| 1. General | ◯ | ◯ | 8. Abdomen | ◯ | ◯ |
| 2. Skin | ◯ | ◯ | 9. Genito-urinary system including hernias | ◯ | ◯ |
| 3. Eyes | ◯ | ◯ | 10. Back/Spine | ◯ | ◯ |
| 4. Ears | ◯ | ◯ | 11. Extremities/joints | ◯ | ◯ |
| 5. Mouth/throat | ◯ | ◯ | 12. Neurological system including reflexes | ◯ | ◯ |
| 6. Cardiovascular | ◯ | ◯ | 13. Gait | ◯ | ◯ |
| 7. Lungs/chest | ◯ | ◯ | 14. Vascular system | ◯ | ◯ |

*Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.*

*(Attach additional sheets if necessary)*

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

***Please complete only one of the following (Federal or State) Medical Examiner Determination sections:***

## MEDICAL EXAMINER DETERMINATION (Federal)

*Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):*

◯ Does not meet standards *(specify reason)*: _____

◯ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

◯ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ◯ 3 months ◯ 6 months ◯ 1 year ◯ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*

◯ Determination pending *(specify reason)*: _____

☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____

☐ Medical Examination Report amended *(specify reason)*: _____

*(if amended)* Medical Examiner's Signature: _____ Date: _____

◯ Incomplete examination *(specify reason)*: _____

**If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____ DOB: _____ Exam Date: _____

## MEDICAL EXAMINER DETERMINATION (State)

*Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):*

◯ Does not meet standards in 49 CFR 391.41 with any applicable State variances *(specify reason)*: _____

◯ Meets standards in 49 CFR 391.41 with any applicable State variances

◯ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ◯ 3 months ◯ 6 months ◯ 1 year ◯ other *(specify)*: _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements *(State)*

**If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: _____ Medical Examiner's Certificate Expiration Date: _____

# Instructions for Completing the Medical Examination Report Form (MCSA-5875)

## I. Step-By-Step Instructions

### Driver:

**Privacy Act Statement** - Please read, sign and date the Statement acknowledging that you understand the provisions of the Privacy Act of 1974 as written.

**Section 1: Driver information**

- **Personal Information**: Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, gender, driver's license number and issuing state.
    - **CLP/CDL Applicant/Holder**: Check "yes" if you are a commercial learner's permit (**CLP**) or commercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
    - **Driver ID Verified By**: The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
    - **Question: Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box “yes” or “no” and if you aren't sure check the “not sure” box.
- **Driver Health History**:
    - **Have you ever had surgery:** Please check “yes” if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
    - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check “yes” if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
    - **#1-32:** Please complete this section by checking the “yes” box to indicate that you have, or have ever had, the health condition listed or the “No” box if you have not. Check the “not sure” box if you are unsure.
    - **Other Health Conditions not described above**: If you have, or have had, any other health conditions not listed in the section above, check “Yes” and in the box provided and list those condition(s).
    - **Any yes answers to questions #1-32 above:** If you have answered “yes” to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered “yes” to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked “yes” to question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

**Medical Examiner**:

**Section 2: Examination Report**

- **Driver Health History Review:** Review answers provided by the driver in the driver health history section and discuss any "yes" and "not sure" responses. In addition, be sure to compare the medication list to the health history responses ensuring that the medication list matches the medical conditions noted. Explore with the driver any answers that seem unclear. Record any information that the driver omitted. As the Medical Examiner conducting the driver's physical examination you are required to complete the entire medical examination even if you detect a medical condition that you consider disqualifying, such as deafness. Medical Examiners are expected to determine the driver's physical qualification for operating a commercial vehicle safely. Thus, if you find a disqualifying condition for which a driver may receive a Federal Motor Carrier Safety Administration medical exemption, please record that on the driver's Medical Examiner's Certificate, Form MCSA-5876, as well as on the Medical Examination Report Form, MCSA-5875.
- **Testing:**
  - **Pulse rate and rhythm, height, and weight:** record these as indicated on the form.
  - **Blood Pressure:** record the blood pressure (systolic and diastolic) of the driver being examined. A second reading is optional and should be recorded if found to be necessary.
  - **Urinalysis:** record the numerical readings for the specific gravity, protein, blood and sugar.
  - **Vision:** The current vision standard is provided on the form. When other than the Snellen chart is used, give test results in Snellen-comparable values. When recording distance vision, use 20 feet as normal. Record the vision acuity results and indicate if the driver can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors; has monocular vision; has been referred to an ophthalmologist or optometrist; and if documentation has been received from an ophthalmologist or optometrist.
  - **Hearing:** The current hearing standard is provided on the form. Hearing can be tested using either a whisper test or audiometric test. Record the test results in the corresponding section for the test used.
- **Physical Examination:** Check the body systems for abnormalities and indicate normal or abnormal for each body system listed. Discuss any abnormal answers in detail in the space provided and indicate whether it would affect the driver's ability to safely operate a commercial motor vehicle.

***In this next section, you will be completing either the Federal or State determination, not both.***

- **Medical Examiner Determination (Federal):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49). Complete the medical examiner determination section completely. When determining a driver's physical qualification, please note that English language proficiency (49 CFR part 391.11: General qualifications of drivers) is not factored into that determination.
  - **Does not meet standards:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41.
  - **Meets standards in 49 CFR 391.41; qualifies for 2-year certification:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified and if selecting other, specify the time frame.
  - **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, driving within an exempt intracity zone, etc.).
- **Determination pending:** Select this option when more information is needed to make a qualification decision and specify a date, on or before the 45 day expiration date, for the driver to return to the medical exam office for follow-up. This will allow for a delay of the qualification decision for as many as 45 days. If the disposition of the pending examination is not updated via the National Registry on or before the 45 day expiration date, FMCSA will notify the examining medical examiner and the driver in writing that the examination is no longer valid and that the driver is required to be re-examined.

- **MER amended:** A Medical Examination Report Form (MER), MCSA-5875, may only be amended while in determination pending status for situations where new information (e.g., test results, etc.) has been received or there has been a change in the driver's medical status since the initial examination, but prior to a final qualification determination. Select this option when a Medical Examination Report Form, MCSA-5875, is being amended; provide the reason for the amendment, sign and date. In addition, initial and date any changes made on the Medical Examination Report Form, MCSA-5875. A Medical Examination Report Form, MCSA-5875, cannot be amended after an examination has been in determination pending status for more than 45 days or after a final qualification determination has been made. The driver is required to obtain a new physical examination and a new Medical Examination Report Form, MCSA-5875, should be completed.

- **Incomplete examination:** Select this when the physical examination is not completed for any reason (e.g., driver decides they do not want to continue with the examination and leaves) other than situations outlined under determination pending.
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, Medical Examiner's Certificate expiration date, signature and date.

- **Medical Examiner Determination (State):** Use this section for examinations performed in accordance with the FMCSRs (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations). Complete the medical examiner determination section completely.
  - **Does not meet standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in 49 CFR 391.41 with any applicable State variances.
  - **Meets standards in 49 CFR 391.41 with any applicable State variances:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner's Certificate.
  - **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified and if selecting other, specify the time frame.
    - **Determination that driver meets standards:** Select all categories that apply to the driver's certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, etc.).

- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, Medical Examiner's Certificate expiration date, signature and date.

**II. If updating an existing exam, you must resubmit the new exam results, via the Medical Examination Results Form, MCSA-5850, to the National Registry, and the most recent dated exam will take precedence.**

**III. To obtain additional information regarding this form go to the Medical Program's page on the Federal Motor Carrier Safety Administration's website at http://www.fmcsa.dot.gov/regulations/medical.**

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

# Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined **Last Name:** _____ **First Name:** _____ in accordance with *(please check only one)*:

◯ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)* ***OR***

◯ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)*:

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____ waiver/exemption
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
- ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*
- ☐ Grandfathered from State requirements *(State)*

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

**Medical Examiner's Certificate Expiration Date**

**Medical Examiner's Signature**

**Medical Examiner's Telephone Number**

**Date Certificate Signed**

**Medical Examiner's Name** ***(please print or type)***

◯ MD ◯ Physician Assistant ◯ Advanced Practice Nurse
◯ DO ◯ Chiropractor ◯ Other Practitioner *(specify)* _____

**Medical Examiner's State License, Certificate, or Registration Number**

**Issuing State**

**National Registry Number**

**Driver's Signature**

**Driver's License Number**

**Issuing State/Province**

**Driver's Address**

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

**CLP/CDL Applicant/Holder**

◯ Yes ◯ No

# DRIVER'S ROAD TEST EXAMINATION

Driver's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

The motor carrier shall give the road test or a person designated by it. However, another person must give a driver who is a motor carrier the test. A person who is competent to evaluate and determine whether the person who takes the test has demonstrated that he or she is capable of operating the vehicle and associated equipment that the motor carrier intends to assign shall give the test.

Rating of Performance

_____ The pre-trip inspection (As required by Sec. 392.7)

_____ Coupling and uncoupling of combination units, if the equipment he or she may drive includes combination units.

_____ Placing the equipment in operation.

_____ Use of vehicle's controls and emergency equipment.

_____ Operating the vehicle in traffic and while passing other vehicles.

_____ Turning the vehicle.

_____ Braking, and slowing the vehicle by means other than braking.

_____ Backing and parking the vehicle.

_____ Other, Explain: _____

_____

Type of equipment used in giving test: _____

_____

Examiner's Signature: _____

Date: _____

# RECORD OF ROAD TEST

**Instructions to Evaluator: Check ( ) items which the driver performs satisfactorily, use "X" where performance is unsatisfactory. Any item not evaluated, leave blank.**

**Driver's Name** _____ **Home Address** _____

**Social Security No.** _____ **License No.** _____ **State** _____ **Class** _____

**Equipment Driven: Truck Tractor** _____ **Trailer(s)** _____
**(Make & Model)** **(Body Type & Length of Each)**

**Length of Test** _____ **Mi. From/In** _____ **To** _____

**Start Time** _____ **Finish Time** _____ **Weather Conditions** _____

## PART 1 - PRE-TRIP INSPECTION AND EMERGENCY EQUIPMENT

Checks general condition approaching unit _____

Checks fuel, oil. Water and for excessive oil on engine _____

Checks around unit - Tires, lights, trailer hook-up, brake and light line, doors and inspects for body damage _____

Tests steering, brake action, tractor protection valve, and parking brake _____

Checks horn, windshield wipers, mirrors, emergency equipment; reflectors, flares, fuses, tire chains (if necessary), fire equipment _____

Checks instruments for normal readings _____

Checks dashboard warning lights for proper functioning _____

Cleans windshield, windows, mirrors, lights and reflectors _____

Reviews and signs previous report _____

## PART 2 - COUPLING AND UNCOUPLING

Connects glad hands to trailer to apply trailer brakes before coupling _____

Connects glad hands and light line properly _____

Couples without difficulty _____

Raises landing gear fully after coupling _____

Visually checks king pin assembly to be certain of proper coupling _____

Checks coupling by applying hand valve or tractor-pro tection valve (trailer air supply valve) and gently applying pressure by trying to pull away from trailer _____

Assures himself that surface will support trailer before uncoupling _____

## PART 3 - PLACING VEHICLE IN MOTION AND USE OF CONTROLS

A. MOTOR
- Places transmission in neutral before starting engine _____
- Starts engine without difficulty _____
- Checks instruments at regular intervals _____
- Maintains proper engine rpm while driving _____

B. BRAKES
- Knows proper use of and checks tractor-protec tion valve (trailer air supply valve) _____
- Tests service brakes _____
- Builds full air pressure before moving _____

C. CLUTCH AND TRANSMISSION
- Starts unit moving smoothly _____
- Uses clutch properly _____

D. LIGHTS (if tested at night)
- Adjusts speed for range of headlights _____
- Dims lights when approaching another vehicle or following other traffic _____

## PART 4 - BACKING AND PARKING

A. BACKING
- Gets out and checks area before backing _____
- Understands and utilizes mirrors properly _____
- Signals when backing (if appropriate) _____
- Avoids backing from blind side _____

B. PARKING (CITY)
- Parks without hitting any other vehicles or station ary objects _____
- Parks correct distance from curb _____
- Secures unit properly - sets parking brake, trans mission in correct gear, shuts off engine, blocks wheels (when necessary) _____
- Carefully enters traffic from parked position _____

C. PARKING (ROAD)
- Parks off pavement _____
- Secures unit properly _____
- Uses emergency warning signal or devices when necessary _____

## PART 5 - SLOWING AND STOPPING

Uses clutch and gears properly _____

Gears down properly before descending hills _____

Starts without rolling back _____

Tests brakes before descending grades _____

Uses brakes properly on grades _____

Makes proper use of mirrors _____

Plans stop far enough in advance to avoid hard braking _____

Stops clear of cf crosswalks _____

## PART 6 - OPERATING IN TRAFFIC, PASSING AND TURNING

A. TURNING
- Signals intention to turn well in advance _____
- Gets into proper lane well in advance of turn _____
- Checks traffic conditions and turns only when intersction is clear _____
- Restricts traffic from passing on right when perparing to complete right hand turn _____
- Completes turn promptly and safely and does not impede other traffic _____

B. TRAFFIC SIGNS AND SIGNALS
- Plans stop in advance and adjusts speed correctly _____
- Obeys all traffic signals _____
- Comes to a complete stop at all stop signs _____

C. INTERSECTIONS
- Yields right of way _____
- Checks for cross traffic regardless of traffic controls _____
- Enters all intersections prepared to stop if necessary _____

D. GRADE CROSSINGS
- Stops at a minimum 15 feet but not more than 50 feet before crossing if stop is necessary _____
- Selects proper gear and does not shift gears while crossing _____
- Knows and understands Federal and State rules governing grade crossings _____

E. PASSING
- Allows sufficient space ahead for passing _____
- Passes only in safe locations _____
- Signals changing lanes before and after passing _____
- Warns driver ahead of his intention to pass _____
- Passes with sufficient speed differential to minimize obstructing traffic _____
- Returns to right lane promptly but only when safe to do so _____

F. SPEED
- Observes speed limits _____
- Drives at speed consistent with ability _____
- Adjusts speed properly to road, weather and traffic conditions _____
- Slows down in advance of curves, danger zones and intersections _____
- Maintains constant speed where possible _____

G. COURTESY AND SAFETY
- Yields right of way _____
- Consistently strives to drive in safe manner _____
- Allows faster traffic to pass _____
- Uses horn only when necessary _____

## PART 7 - MISCELLANEOUS

A. GENERAL DRIVING ABILITY AND HABITS
- Consistently alert and attentive _____
- Consistently is aware of changing traffic conditions _____
- anticipates problems _____
- Performs routine functions without taking eyes from road _____
- Checks instruments regularly while driving _____
- Personal appearance is professional _____
- Remains calm under pressure _____

B. USE OF SPECIAL EQUIPMENT (SPECIFY)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

REMARKS:

_____

_____

_____

GENERAL PERFORMANCE: Satisfactory ☐ Needs Training ☐ Explain: _____

_____

QUALIFIED FOR: Straight Truck ☐ Tractor-Semitrailer ☐ Twin Trailers ☐ Other Combination ☐

Special Equipment _____
(SPECIFY)

_____ Date _____
SIGNATURE OF EXAMINER

(version 06/07/16)

## CERTIFICATION OF ROAD TEST

Driver's Name _____

_____ _____ _____ _____ _____
(Social Security Number) (Operators or Chauffeurs License Number) (State)

Type of Power Unit _____ Type of Trailer(s) _____

If passenger carrier, type of bus _____

This is to certify that the above named driver was given a road test under my supervision on

_____, 20_____ consisting of approximately _____

miles of driving.

It is my considered opinion that this driver possesses sufficient driving skill to operate safely the type of commercial motor vehicle listed above.

_____ _____
(Signature of Examiner) (Title)

_____
(Organization and Address of Examiner)

# APPLICATION FOR EMPLOYMENT

COMPANY _____ STREET ADDRESS _____

CITY, STATE AND ZIP CODE _____

NAME _____
(FIRST) (MIDDLE) (Maiden Name, if any) (LAST)

ADDRESS _____ HOW LONG? _____
(STREET) (CITY) (STATE & ZIP CODE)

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

TELEPHONE NUMBER _____ E-MAIL ADDRESS _____

ADDRESS FOR PAST THREE YEARS

_____ HOW LONG? _____
(STREET) (CITY) (STATE & ZIP CODE)

_____ HOW LONG? _____
(STREET) (CITY) (STATE & ZIP CODE)

**(ATTACH SHEET IF MORE SPACE IS NEEDED)**

EXPERIENCE AND QUALIFICATIONS - DRIVER

| | STATE | LICENSE NO. | TYPE | EXPIRATION DATE |
|---|---|---|---|---|
| DRIVER LICENSES | | | | |
| | | | | |
| | | | | |

DRIVING EXPERIENCE

| CLASS OF EQUIPMENT | TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.) | DATES FROM TO | APPROX. NO. OF MILES (TOTAL) |
|---|---|---|---|
| STRAIGHT TRUCK | | | |
| TRACTOR AND SEMI-TRAILER | | | |
| TRACTOR - TWO TRAILERS | | | |
| OTHER | | | |

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MOR SPACE IS NEEDED)

| DATES | NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.) | FATALITIES | INJURIES |
|---|---|---|---|
| LAST ACCIDENT | | | |
| NEXT PREVIOUS | | | |
| NEXT PREVIOUS | | | |

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

| LOCATION | DATE | CHARGE | PENALTY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

(ATTACH SHEET IF MORE SPACE IS NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES _____ NO _____

B. Has any license, permit or privilege ever been suspended or revoked? YES _____ NO _____

(IF THE ANSWER TO EITHER A OR B IS YES, ATTACH STATEMENT GIVING DETAILS)

EMPLOYMENT RECORD (Attach Sheet If More Space Is Needed)

NOTE: DOT requires that employment for at least 3 years and/or commercial driving experience for the past 10 years be shown.

LAST EMPLOYER: NAME _____

ADDRESS _____

POSITION HELD _____ FROM _____ TO _____SALARY _____

REASONS FOR LEAVING _____

SECOND LAST EMPLOYER: NAME _____

ADDRESS _____

POSITION HELD _____ FROM _____ TO _____SALARY _____

REASONS FOR LEAVING _____

THIRD LAST EMPLOYER: NAME _____

ADDRESS _____

POSITION HELD _____ FROM _____ TO _____SALARY _____

REASONS FOR LEAVING _____

TO BE READ AND SIGNED BY APPLICANT

This certifies that I completed this application, and that all entries on it and information in it are true and complete to the best of my knowledge.

_____ _____

DATE APPLICANT'S SIGNATURE

Note: A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.

(version 06/07/16)

# SPEC-2 FORM (APPLICANT WITH IMPAIRED VISION)

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

## APPLICATION FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

| **MAIL COMPLETED FORM TO:** | ATTN: MEDICAL EXEMPTION PROGRAM<br>MOTOR CARRIER SERVICES<br>PO BOX 270<br>JEFFERSON CITY, MO 65102-0270 | IF ASSISTANCE NEEDED, CALL:<br>573-522-4937 OR Toll Free at 866-831-6277<br>FAX 573-522-4260 |
|---|---|---|

### SECTION 1. INDIVIDUAL OR JOINT APPLICATION

| | |
|---|---|
| ☐ ← CHECK THIS BOX IF INDIVIDUAL DRIVER APPLICATION. SECTIONS 1 TO 8 OF APPLICATION MUST BE COMPLETED. | ☐ ← CHECK THIS BOX IF JOINT APPLICATION, BY DRIVER-APPLICANT WITH CO-APPLICANT MOTOR CARRIER. ALL 9 SECTIONS OF APPLICATION MUST BE COMPLETED, AS INDICATED. |

### SECTION 2. IDENTIFICATION OF DRIVER-APPLICANT

(Note: If joint application, please identify the co-applicant motor carrier below in Section 9).

| | | | |
|---|---|---|---|
| DRIVER-APPLICANT'S FULL NAME | | | MAIDEN/FORMER NAME(S) |
| RESIDENCE ADDRESS | | | GENDER (PLEASE CHECK ONE BOX) ☐ MALE ☐ FEMALE |
| CITY | STATE | ZIP | DATE OF BIRTH |
| (AREA CODE) HOME TELEPHONE # ( ) | (AREA CODE) WORK PHONE # (IF ANY) ( ) | | SOCIAL SECURITY # |
| DRIVER'S LICENSE # | STATE WHICH ISSUED | DATE ISSUED | EXPIRATION DATE |

| | |
|---|---|
| A ☐ | DRIVER-APPLICANT MUST ATTACH COPY OF HIS/HER CURRENT MOTOR VEHICLE DRIVER'S LICENSE.<br>← CHECK BOX TO CONFIRM THAT COPY OF DRIVER-APPLICANT'S CURRENT DRIVER'S LICENSE IS ATTACHED. |
| DESCRIPTION OF DRIVER-APPLICANT'S VISION IMPAIRMENT | |

### SECTION 3. DRIVER-APPLICANT'S CURRENT EMPLOYMENT

(COMPLETE THIS SECTION WHETHER INDIVIDUAL DRIVER APPLICATION, OR JOINT APPLICATION WITH CO-APPLICANT MOTOR CARRIER.)

| | | |
|---|---|---|
| A ☐ ← CHECK BOX IF APPLICANT IS NOW EMPLOYED BY A MOTOR CARRIER. | B ☐ ← CHECK BOX IF APPLICANT IS NOW EMPLOYED, BUT NOT BY ANY MOTOR CARRIER. | C ☐ ← CHECK BOX IF APPLICANT IS NOT CURRENTLY EMPLOYED (SKIP NEXT TWO ROWS). |
| CURRENT EMPLOYER'S NAME | | EMPLOYER'S USDOT # (IF ANY) |
| CURRENT EMPLOYER'S ADDRESS, CITY, STATE, ZIP | | |

### SECTION 4. TYPE OF OPERATION DRIVER-APPLICANT WILL BE EMPLOYED TO PERFORM

| | |
|---|---|
| STATES WHERE APPLICANT HAS OPERATED COMMERCIAL MOTOR VEHICLES | TYPES OF CARGO TO BE TRANSPORTED |
| EXPECTED AVERAGE DRIVING TIME AND ON-DUTY TIME, PER DAY | TYPE OF DRIVER OPERATION (SLEEPER TEAM, RELAY, OWNER-OPERATOR, ETC.) |
| NUMBER OF YEARS' EXPERIENCE DRIVING TYPE OF VEHICLE(S) DESCRIBED IN APPLICATION | TOTAL YEARS' EXPERIENCE DRIVING ALL TYPES OF COMMERCIAL MOTOR VEHICLES |

| | |
|---|---|
| A ☐ | APPLICANT MUST ATTACH COPY OF HIS/HER **APPLICATION FOR EMPLOYMENT**, WHICH HAS BEEN COMPLETED PURSUANT TO 49 CFR 391.21.<br>← CHECK BOX TO CONFIRM THAT COMPLETED APPLICATION FOR EMPLOYMENT IS ATTACHED. |
| B ☐ | APPLICANT MUST ATTACH A **CERTIFIED COPY OF HIS/HER STATE MOTOR VEHICLE DRIVING RECORD**, FROM THE STATE OF HIS/HER CURRENT RESIDENCE, AND FROM EVERY OTHER STATE OR PROVINCE IN WHICH DRIVER-APPLICANT RESIDED WITHIN 3 YEARS BEFORE FILING THIS APPLICATION.<br>← CHECK BOX TO CONFIRM THAT APPLICANT'S DRIVING RECORD IS ATTACHED. |
| C ☐ | APPLICANT MUST ATTACH A COPY OF HIS/HER **CERTIFICATE OF DRIVER'S ROAD TEST,** OR EQUIVALENT CDL, AS PROVIDED IN 49 CFR 391.31 OR 391.33.<br>← CHECK BOX TO CONFIRM THAT THE CERTIFICATE OF DRIVER'S ROAD TEST (OR CDL IF DEEMED EQUIVALENT UNDER 49 CFR 391.33) IS ATTACHED. |
| D ☐ | APPLICANT MUST ATTACH AN **AFFIDAVIT OF DRIVING EXPERIENCE, SPEC-E FORM** COMPLETED BY PRESENT AND/OR PAST EMPLOYER(S).<br>← CHECK BOX TO CONFIRM THAT THE AFFIDAVIT OF DRIVING EXPERIENCE FORM IS ATTACHED. |

## SECTION 5. DESCRIPTION OF VEHICLE DRIVER-APPLICANT SEEKS TO DRIVE

| | | |
|---|---|---|
| VEHICLE TYPE: (Truck, Truck-Tractor, Bus, Limo, Etc.) | | PASSENGER SEATING CAPACITY, INCLUDING DRIVER: |
| MAKE: | MODEL: | YEAR: |
| TRANSMISSION TYPE: (Automatic, Manual) | | NO. OF FORWARD SPEEDS: |
| IF EQUIPPED WITH AUXILIARY TRANSMISSION, INDICATE NUMBER OF FORWARD SPEEDS: | | REAR AXLE SPEED: (*E.G.* Single Speed, 2-Speed, 3-Speed) |
| TYPE OF BRAKE SYSTEM: | | |
| STEERING: (Manual Or Power Assisted) | | NUMBER OF SEMITRAILERS OR FULL TRAILERS TO BE TOWED AT ONE TIME: |
| DESCRIPTION OF TRAILERS: (Van, Flatbed, Cargo Tank, Lowboy, Pole, Dump, Etc.) | | |
| DESCRIPTION OF VEHICLE MODIFICATIONS RELATING TO VISION IMPAIRMENT: (Must Be Currently Installed On Vehicles) | | |

## SECTION 6. DRIVER-APPLICANT'S REQUIRED MEDICAL DOCUMENTATION

| | |
|---|---|
| A ☐ | APPLICANT MUST ATTACH A COPY OF THE **MEDICAL EXAMINATION REPORT**, AS PRESCRIBED IN 49 CFR SECTION 391.43**(F)**, COMPLETED BY THE APPLICANT AND A LICENSED MEDICAL EXAMINER AS DEFINED IN 49 CFR SECTION 390.5. ←CHECK BOX TO CONFIRM THAT THE COMPLETED MEDICAL EXAMINATION REPORT IS ATTACHED. |
| B ☐ | APPLICANT MUST ATTACH A COPY OF THE **MEDICAL EXAMINER'S CERTIFICATE**, AS PRESCRIBED IN 49 CFR SECTION 391.43**(H)**, COMPLETED BY THE APPLICANT AND A LICENSED MEDICAL EXAMINER AS DEFINED IN 49 CFR SECTION 390.5. ←CHECK BOX TO CONFIRM THAT THE COMPLETED MEDICAL EXAMINER'S CERTIFICATE IS ATTACHED. |
| C ☐ | APPLICANT MUST ATTACH A COPY OF THE **OPTOMETRIST/OPHTHALMOLOGIST CERTIFICATION, SPEC-D FORM,** WHICH MUST BE COMPLETED BY APPLICANT AND A **BOARD-CERTIFIED OR BOARD-ELIIGIBLE OPTHALMOLOGIST OR OPTOMETRIST.** (GENERAL PRACTITIONER IS NOT ACCEPTABLE!) ←CHECK BOX TO CONFIRM THAT THE COMPLETED OPTOMETRIST/ OPHTHALMOLOGIST CERTIFICATION IS ATTACHED. |
| D ☐ | IF THE APPLICANT HAS INSULIN-TREATED DIABETES MELLITIS (ITDM), HE OR SHE MUST BE EXAMINED BY AN **OPHTHALMOLOGIST (NOT AN OPTOMETRIST)** AND MUST SUBMIT THE REQUIRED **SPEC-D FORM** COMPLETED BY AN OPHTHALMOLOGIST, WHICH MUST CERTIFY THAT THE APPLICANT DOES NOT HAVE UNSTABLE PROLIFERATIVE DIABETIC RETINOPATHY (I.E., UNSTABLE ADVANCING DISEASE OF BLOOD VESSELS IN THE RETINA). IN ADDITION, EVERY APPLICANT WITH ITDM MUST ALSO SUBMIT A COMPLETED **SPEC-3 FORM** APPLICATION, BE EXAMINED BY A BOARD-CERTIFIED OR BOARD-ELIGIBLE ENDOCRINOLOGIST (A MEDICAL SPECIALIST WHO IS KNOWLEDGEABLE ABOUT DIABETES), AND A COMPLETED **SPEC-F FORM**, ENDOCRINOLOGIST CERTIFICATION. ←CHECK BOX TO CONFIRM THAT THE COMPLETED **SPEC-3 FORM.** APPLICATION IS ATTACHED. |
| E ☐ | ←CHECK BOX TO CONFIRM THAT THE COMPLETED **SPEC-F FORM,** ENDOCRINOLOGIST CERTIFICATION IS ATTACHED. |
| F YES ☐ NO ☐ | DOES THE APPLICANT NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH DIABETES? |
| G YES ☐ NO ☐ | DOES THE APPLICANT NOW HAVE OR HAS HE/SHE EVER BEEN TREATED FOR INSULIN-TREATED DIABETES MELLITUS (ITDM)? |

## SECTION 7. DRIVER-APPLICANT'S OTHER SPE CERTIFICATIONS, MEDICAL WAIVERS AND EXEMPTIONS

| | |
|---|---|
| A ☐ | IF APPLICANT POSSESSES A CURRENTLY VALID SPE CERTIFICATE, WAIVER, OR EXEMPTION FROM ANY PHYSICAL REQUIREMENTS FOR DRIVERS OF COMMERCIAL MOTOR VEHICLES, ISSUED BY THE FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION (FMCSA), MODOT MAY SUMMARILY ISSUE TO DRIVER-APPLICANT A SPE CERTIFICATE AUTHORIZING INTRASTATE OPERATION OF SIMILAR COMMERCIAL MOTOR VEHICLES WITHIN MISSOURI. APPLICANT MUST ATTACH TRUE COPIES OF ALL CURRENTLY VALID SPE CERTIFICATES, WAIVERS AND EXEMPTIONS FROM PHYSICAL REQUIREMENTS THAT HAVE BEEN ISSUED TO APPLICANT. ←CHECK BOX TO CONFIRM THAT COPY OF DRIVER-APPLICANT'S OTHER CURRENT SPE CERTIFICATES, WAIVERS AND EXEMPTTIONS ARE ATTACHED. |

**APPLICANT MUST DISCLOSE WHETHER HE/SHE HAS EVER OBTAINED ANY SPE CERTIFICATE, WAIVER OR EXEMPTION RELATING TO ANY PHYSICAL QUALIFICATIONS FOR DRIVERS OF COMMERCIAL MOTOR VEHICLES, OR HAS HAD ANY SPE CERTIFICATE, WAIVER, EXEMPTION, OR APPLICATION THEREFOR DENIED, DISMISSED, SUSPENDED, REVOKED OR WITHDRAWN, EITHER BY FMCSA, OR BY ANY STATE OR PROVINCE.**

| | |
|---|---|
| B ☐ | ←CHECK THIS BOX IF DRIVER-APPLICANT HAS NEVER OBTAINED ANY SPE CERTIFICATE, WAIVER OR EXEMPTION RELATING TO PHYSICAL QUALIFICATIONS REQUIRED FOR DRIVERS OF COMMERCIAL MOTOR VEHICLES, AND HAS NEVER HAD ANY SPE CERTIFICATE, WAIVER, EXEMPTION, OR APPLICATION THEREFOR DENIED, DISMISSED, SUSPENDED, REVOKED OR WITHDRAWN, EITHER BY FMCSA, OR BY ANY STATE OR PROVINCE. |
| C ☐ | IF DRIVER-APPLICANT HAS PREVIOUSLY OBTAINED, OR NOW POSSESSES, ANY SPE CERTIFICATE, WAIVER OR EXEMPTION FROM ANY PHYSICAL QUALIFICATION REQUIRED FOR DRIVERS OF COMMERCIAL MOTOR VEHICLES, HE/SHE MUST ATTACH COPIES OF ALL THOSE SPE CERTIFICATES, AND DOCUMENTATION OF ALL THOSE WAIVERS AND EXEMPTIONS TO THIS APPLICATION. ←CHECK BOX TO CONFIRM THAT DRIVER-APPLICANT HAS ATTACHED COPIES OF ALL OTHER SPE CERTIFICATES, WAIVERS AND EXEMPTIONS. |

***NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.***

## SECTION 7. DRIVER-APPLICANT'S OTHER SPE CERTIFICATIONS, MEDICAL WAIVERS AND EXEMPTIONS (*CONTINUED)*

| | |
|---|---|
| D ☐ | IF DRIVER-APPLICANT HAS PREVIOUSLY APPLIED FOR OR OBTAINED ANY SPE CERTIFICATE, WAIVER OR EXEMPTION FROM ANY PHYSICAL QUALIFICATION REQUIRED FOR DRIVERS OF COMMERCIAL MOTOR VEHICLES, AND HAS HAD ANY SPE CERTIFICATE, WAIVER, EXEMPTION, OR APPLICATION THEREFOR DENIED, DISMISSED, SUSPENDED, REVOKED OR WITHDRAWN, APPLICANT MUST ATTACH COPIES OF EACH FINAL NOTICE, ORDER, OR OTHER OFFICIAL DOCUMENTATION OF THE DENIAL, DISMISSAL, SUSPENSION, REVOCATION, DENIAL OR WITHDRAWAL.<br>←CHECK BOX TO CONFIRM THAT DRIVER-APPLICANT HAS ATTACHED COPIES OF ALL DENIALS, DISMISSALS, SUSPENSIONS, REVOCATIONS AND WITHDRAWALS OF ANY OTHER SPE CERTIFICATE, WAIVER OR EXEMPTION, WHICH HE/SHE PREVIOUSLY APPLIED FOR OR OBTAINED. |

## SECTION 8. DRIVER-APPLICANT'S CERTIFICATION AND VERIFICATION

I CERTIFY THAT, EXCEPT FOR THE PHYSICAL CONDITION(S) INDICATED ABOVE, I AM OTHERWISE FULLY QUALIFIED UNDER PART 391 ("QUALIFICATION OF DRIVERS") OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS (TITLE 49, CODE OF FEDERAL REGULATIONS) TO DRIVE AND OPERATE COMMERCIAL MOTOR VEHICLES.

I CERTIFY THAT I HAVE DISCLOSED TO ALL MEDICAL PROFESSIONALS WHO ARE IDENTIFIED IN THIS FORM AND ALL ATTACHMENTS, THE FULL, TRUE AND CORRECT INFORMATION CONCERNING MY MEDICAL HISTORY AND MY PRESENT PHYSICAL CONDITION.

I EXPRESSLY AUTHORIZE THE MISSOURI DEPARTMENT OF TRANSPORTATION, THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION, AND THEIR AUTHORIZED PERSONNEL, TO FURTHER INVESTIGATE MY QUALIFICATIONS, AND I AUTHORIZE ALL PHYSICIANS, HOSPITALS, PHARMACIES, AND ALL OTHER HEALTH CARE PROVIDERS OR HEALTH INSURERS TO ALLOW ACCESS AND PROVIDE COPIES OF ALL OF MY PERSONAL MEDICAL RECORDS TO AUTHORIZED PERSONNEL OF THE MISSOURI DEPARTMENT OF TRANSPORTATION OR THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION FOR THESE PURPOSES.

I CERTIFY THAT IF ANY INFORMATION PROVIDED TO MODOT IN RELATION TO THIS APPLICATION, INCLUDING (BUT NOT LIMITED TO) MY ADDRESS, PHYSICAL CONDITION, DRIVING RECORD, LICENSE STATUS, OR ANY OTHER PERTINENT INFORMATION, SHALL CHANGE OR BECOME INCORRECT AFTER THIS DATE, THEN I WILL IMMEDIATELY FILE AMENDED OR SUPPLEMENTAL INFORMATION, SO THAT ALL RELEVANT INFORMATION PROVIDED TO MODOT IS KEPT CURRENT AND ACCURATE.

I UNDERSTAND THAT, IF A SPE CERTIFICATE IS ISSUED TO ME, THEREAFTER MODOT MAY SUSPEND AND REVOKE ANY SPE CERTIFICATE ISSUED TO ME IF I VIOLATE OR FAIL TO COMPLY WITH ANY APPLICABLE TRAFFIC LAWS, REGULATIONS OR ORDERS, OR ANY CONDITIONS STATED IN MY SPE CERTIFICATE, OR IF I AM INVOLVED IN ANY TRAFFIC ACCIDENT OR CRASH WHILE DRIVING ANY MOTOR VEHICLE.

**I FURTHER DECLARE UNDER PENALTY OF PERJURY** UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

| APPLICANT'S SIGNATURE | DATE SIGNED: |
|---|---|
| APPLICANT'S NAME (Printed) | |

## SECTION 9. CO-APPLICANT MOTOR CARRIER'S CERTIFICATION AND VERIFICATION

THE UNDERSIGNED CO-APPLICANT MOTOR CARRIER CERTIFIES THAT IT INTENDS TO EMPLOY THE DRIVER-APPLICANT IF HE/SHE IS GRANTED A SPE CERTIFICATE AS REQUESTED IN THIS APPLICATION, AND THAT CO-APPLICANT WILL FULFILL ALL OBLIGATIONS OF THE MOTOR CARRIER'S AGREEMENT AS REQUIRED PURSUANT TO 49 CFR 391.49(E). THESE OBLIGATIONS INCLUDE, BUT ARE NOT LIMITED TO, THE REQUIREMENT THAT CO-APPLICANT WILL FILE WITH MISSOURI MOTOR CARRIER SERVICES (ATTN: MEDICAL EXEMPTION PROGRAM) SUCH DOCUMENTS AND INFORMATION AS MAY BE REQUIRED ABOUT DRIVING ACTIVITIES, ACCIDENTS, ARRESTS, LICENSE SUSPENSIONS OR REVOCATIONS, AND CONVICTIONS, WHICH INVOLVE THE DRIVER-APPLICANT.

**THE UNDERSIGNED INDIVIDUAL FURTHER DECLARES UNDER PENALTY OF PERJURY** UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT, AND THAT THE SIGNATURE BELOW IS THE CO-APPLICANT'S OWN TRUE SIGNATURE, OR IS MADE ON CO-APPLICANT'S BEHALF BY A DULY-AUTHORIZED OFFICER OR AGENT OF CO-APPLICANT.

| CO-APPLICANT MOTOR CARRIER'S NAME | USDOT # | (AREA CODE) TELEPHONE #<br>( ) |
|---|---|---|
| CO-APPLICANT'S ADDRESS, CITY, STATE, ZIP | | |
| SIGNATURE OF CO-APPLICANT (Or Authorized Officer Or Agent) | DATE SIGNED: | |
| NAME OF SIGNING OFFICER OR AGENT (Printed) | TITLE OF SIGNING OFFICER OR AGENT | |

*NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.*

# SPEC-D FORM (Optometrist/Ophthalmologist Certification)

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

## CERTIFICATION BY LICENSED VISION PROFESSIONAL FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

| **MAIL COMPLETED FORM TO:** | ATTN: MEDICAL EXEMPTION PROGRAM<br>MOTOR CARRIER SERVICES<br>PO BOX 270<br>JEFFERSON CITY, MO 65102-0270 | IF ASSISTANCE NEEDED, CALL:<br>573-522-4937 OR Toll Free at 866-831-6277<br>FAX 573-522-4260 |
|---|---|---|

**SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT** (TO BE COMPLETED BY DRIVER APPLICANT.)

| DRIVER-APPLICANT'S FULL NAME | | | MAIDEN/FORMER NAME(S) |
|---|---|---|---|
| RESIDENCE ADDRESS | | | GENDER (PLEASE CHECK ONE BOX)<br>☐ MALE ☐ FEMALE |
| CITY | STATE | ZIP | DATE OF BIRTH |
| (AREA CODE) HOME TELEPHONE #<br>( ) | (AREA CODE) WORK PHONE # (IF ANY)<br>( ) | | SOCIAL SECURITY # |

**SECTION 2. IDENTIFICATION OF VISION PROFESSIONAL**
(SECTIONS 2-7 TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST.)

| VISION PROFESSIONAL'S BUSINESS NAME | | | BOARD CERTIFIED<br>☐ YES ☐ NO |
|---|---|---|---|
| VISION PROFESSIONAL'S FULL NAME | | | BOARD ELIGIBLE<br>☐ YES ☐ NO |
| BUSINESS ADDRESS | | | |
| CITY | STATE | ZIP | |
| (AREA CODE) OFFICE TELEPHONE #<br>( ) | (AREA CODE) OFFICE FAX #<br>( ) | | PROFESSIONAL CERTIFICATION # |
| FIELD OF SPECIALTY (PLEASE CHECK ONE BOX)<br>☐ OPHTHALMOLOGIST ☐ OPTOMETRIST | | | PROFESSIONAL LICENSE # |
| NAME OF CERTIFYING ORGANIZATION | | | |
| ADDRESS OF CERTIFYING ORGANIZATION | | | |
| CITY | STATE | ZIP | |

**SECTION 3. NATURE OF THE VISION DEFICIENCY AND DATE OF IMPAIRMENT**

| | |
|---|---|
| | DATE OF IMPAIRMENT: |

***NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.***

## SECTION 4. VISUAL ACUITY

| RIGHT EYE | CORRECTED: | LEFT EYE | CORRECTED: |
|---|---|---|---|
| | UNCORRECTED: | | UNCORRECTED: |

## SECTION 5. TO BE COMPLETED BY OPTHALMOLOGIST IF APPLICANT HAS INSULIN-TREATED DIABETES MELLITUS (ITDM). (OPTOMETRIST IS NOT ACCEPTABLE IF APPLICANT HAS DIABETES.)

| | |
|---|---|
| A YES ☐ NO ☐ | DOES THE APPLICANT HAVE ANY EVIDENCE OF DIABETIC RETINOPATHY (I.E., DISEASE OF BLOOD VESSELS IN THE RETINA)? EXPLAIN: |

| | |
|---|---|
| B YES ☐ NO ☐ | DOES THE APPLICANT HAVE ANY EVIDENCE OF DIABETIC RETINOPATHY, HE OR SHE MUST BE EXAMINED BY A **BOARD-CERTIFIED**, OR **BOARD-ELIGIBLE ENDOCRINOLOGIST.** EXPLAIN: |

| | |
|---|---|
| C ☐ | FIELD OF VISION - PLEASE GIVE A BRIEF DESCRIPTION OF THE APPLICANT'S MEDICAL CONDITION FOR WHICH A SKILL PERFORMANCE EVALUATION CERTIFICATE IS NECESSARY. ←CHECK BOX TO CONFIRM COMPLETION. |

| | |
|---|---|
| D ☐ | IS THE PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH ACTUAL TREATMENT? ←CHECK BOX TO CONFIRM COMPLETION. |

| | | |
|---|---|---|
| ☐ YES - HOW LONG? | | ☐ NO - EXPLAIN: |

| | |
|---|---|
| E ☐ | VISION PROFESSIONAL MUST ATTACH FORMAL PERIMETRY THAT IDENTIFIES THE FIELD OF VISION OF EACH EYE, INCLUDING CENTRAL AND PERIPHERAL FIELDS, TESTING TO AT LEAST 120° IN THE HORIZONTAL FOR EACH EYE, AS WELL AS AN INTERPRETATION OF THE RESULTS IN DEGREES OF FIELD OF VISION. ←CHECK BOX TO CONFIRM THAT THE COMPLETED FORMAL PERIMETRY AND INTERPRETATION REPORT IS ATTACHED. |

## SECTION 6. VISION PROFESSIONAL'S CERTIFICATION

| | |
|---|---|
| A YES ☐ NO ☐ | I CERTIFY THAT, IN MY MEDICAL OPINION, THE APPLICANT'S VISUAL DEFICIENCY IS STABLE AND HAS SUFFICIENT VISION TO PERFORM THE DRIVING TASKS REQUIRED TO OPERATE A COMMERCIAL MOTOR VEHICLE, AND THAT THE APPLICANT'S CONDITION WILL NOT ADVERSELY AFFECT HIS/HER ABILITY TO OPERATE A COMMERCIAL MOTOR VEHICLE SAFELY. |

***NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.***

## SECTION 7. DRIVER-APPLICANT'S CERTIFICATION AND VERIFICATION

I CERTIFY THAT, EXCEPT FOR THE PHYSICAL CONDITION(S) INDICATED ABOVE, I AM OTHERWISE FULLY QUALIFIED UNDER PART 391 ("QUALIFICATION OF DRIVERS") OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS (TITLE 49, CODE OF FEDERAL REGULATIONS) TO DRIVE AND OPERATE COMMERCIAL MOTOR VEHICLES.

I CERTIFY THAT I HAVE DISCLOSED TO ALL MEDICAL PROFESSIONALS WHO ARE IDENTIFIED IN THIS FORM AND ALL ATTACHMENTS, THE FULL, TRUE AND CORRECT INFORMATION CONCERNING MY MEDICAL HISTORY AND MY PRESENT PHYSICAL CONDITION.

I EXPRESSLY AUTHORIZE THE MISSOURI DEPARTMENT OF TRANSPORTATION, THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION, AND THEIR AUTHORIZED PERSONNEL, TO FURTHER INVESTIGATE MY QUALIFICATIONS, AND I AUTHORIZE ALL PHYSICIANS, HOSPITALS, PHARMACIES, AND ALL OTHER HEALTH CARE PROVIDERS OR HEALTH INSURERS TO ALLOW ACCESS AND PROVIDE COPIES OF ALL OF MY PERSONAL MEDICAL RECORDS TO AUTHORIZED PERSONNEL OF THE MISSOURI DEPARTMENT OF TRANSPORTATION OR THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION FOR THESE PURPOSES.

I CERTIFY THAT IF ANY INFORMATION PROVIDED TO MODOT IN RELATION TO THIS APPLICATION, INCLUDING (BUT NOT LIMITED TO) MY ADDRESS, PHYSICAL CONDITION, DRIVING RECORD, LICENSE STATUS, OR ANY OTHER PERTINENT INFORMATION, SHALL CHANGE OR BECOME INCORRECT AFTER THIS DATE, THEN I WILL IMMEDIATELY FILE AMENDED OR SUPPLEMENTAL INFORMATION, SO THAT ALL RELEVANT INFORMATION PROVIDED TO MODOT IS KEPT CURRENT AND ACCURATE.

I UNDERSTAND THAT, IF A SPE CERTIFICATE IS ISSUED TO ME, THEREAFTER MODOT MAY SUSPEND AND REVOKE ANY SPE CERTIFICATE ISSUED TO ME IF I VIOLATE OR FAIL TO COMPLY WITH ANY APPLICABLE TRAFFIC LAWS, REGULATIONS OR ORDERS, OR ANY CONDITIONS STATED IN MY SPE CERTIFICATE, OR IF I AM INVOLVED IN ANY TRAFFIC ACCIDENT OR CRASH WHILE DRIVING ANY MOTOR VEHICLE.

**I FURTHER DECLARE UNDER PENALTY OF PERJURY** UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

| APPLICANT'S SIGNATURE | DATE SIGNED: |
|---|---|
| APPLICANT'S NAME (Printed) | |

## SECTION 8. VISION PROFESSIONAL'S VERIFICATION

**I FURTHER DECLARE UNDER PENALTY OF PERJURY** UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

| VISION PROFESSIONAL'S NAME (Printed) | |
|---|---|
| VISION PROFESSIONAL'S SIGNATURE | DATE SIGNED: |

*NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.*

# SPEC-E FORM

(AFFIDAVIT OF DRIVING EXPERIENCE)

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

## VERIFICATION OF DRIVING EXPERIENCE FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

| **MAIL COMPLETED FORM TO:** | ATTN: MEDICAL EXEMPTION PROGRAM<br>MOTOR CARRIER SERVICES<br>PO BOX 270<br>JEFFERSON CITY, MO 65102-0270 | IF ASSISTANCE NEEDED, CALL:<br>573-522-4937 OR Toll Free at 866-831-6277<br>FAX 573-522-4260 |
|---|---|---|

**SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT**

| DRIVER-APPLICANT'S FULL NAME | | | |
|---|---|---|---|
| RESIDENCE ADDRESS | | | DATE OF BIRTH |
| CITY | STATE | ZIP | SOCIAL SECURITY # |

**SECTION 2. DRIVER-APPLICANT'S EMPLOYER**

| | |
|---|---|
| A<br>YES ☐ NO ☐ | IS APPLICANT PRESENTLY EMPLOYED BY YOU TO OPERATE A COMMERCIAL MOTOR VEHICLE(S)? |
| B<br>YES ☐ NO ☐ | HAVE YOU PREVIOUSLY EMPLOYED APPLICANT TO OPERATE A COMMERCIAL MOTOR VEHICLE, BUT APPLICANT NO LONGER WORKS FOR YOU. |

| EMPLOYER'S NAME | | | EMPLOYER'S USDOT # OR ICC# |
|---|---|---|---|
| EMPLOYER'S ADDRESS | | | |
| CITY | STATE | ZIP | (AREA CODE) TELEPHONE #<br>( ) |

**SECTION 3. TYPE OF OPERATION DRIVER-APPLICANT PERFORMS OR PERFORMED FOR YOU**

| VEHICLE TYPE: (TRUCK, TRUCK-TRACTOR, BUS, LIMO, ETC.) | VEHICLE MAKE: | VEHICLE MODEL: | VEHICLE YEAR: |
|---|---|---|---|
| MANUFACTURER'S GROSS VEHICLE WEIGHT RATING (GVWR) OF VEHICLE DRIVEN BY APPLICANT | | | |
| VEHICLE LICENSED WEIGHT (LICENSE PLATE) OF VEHICLE DRIVEN BY APPLICANT | | | |

| | |
|---|---|
| AVERAGE HOURS PER WEEK DRIVEN ON PUBLIC HIGHWAYS | |
| DATE (MONTH/DAY/YEAR) APPLICANT STOPPED DRIVING FOR YOU | |
| DATE (MONTH/DAY/YEAR) APPLICANT STARTED DRIVING FOR YOU | |

**SECTION 4. DESCRIPTION OF DRIVER'S PERFORMANCE**

| | |
|---|---|
| A☐ | PLEASE DESCRIBE IN YOUR OWN WORDS, THE DRIVER'S PERFORMANCE WHILE UNDER YOUR EMPLOYMENT AS A DRIVER. PLEASE INCLUDE ANY AND ALL DETAILS YOU DEAM RELEVANT TO THE DRIVER'S QUALIFICATIONS.<br>← CHECK BOX IF MORE SPACE IS NEEDED AND YOU USE THE BACKSIDE OF THIS FORM. |

*NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.*

## SECTION 5. DRIVER-APPLICANT'S CERTIFICATION AND VERIFICATION

I CERTIFY THAT, EXCEPT FOR THE PHYSICAL CONDITION(S) INDICATED ABOVE, I AM OTHERWISE FULLY QUALIFIED UNDER PART 391 ("QUALIFICATION OF DRIVERS") OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS (TITLE 49, CODE OF FEDERAL REGULATIONS) TO DRIVE AND OPERATE COMMERCIAL MOTOR VEHICLES.

I CERTIFY THAT I HAVE DISCLOSED TO ALL MEDICAL PROFESSIONALS WHO ARE IDENTIFIED IN THIS FORM AND ALL ATTACHMENTS, THE FULL, TRUE AND CORRECT INFORMATION CONCERNING MY MEDICAL HISTORY AND MY PRESENT PHYSICAL CONDITION.

I EXPRESSLY AUTHORIZE THE MISSOURI DEPARTMENT OF TRANSPORTATION, THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION, AND THEIR AUTHORIZED PERSONNEL, TO FURTHER INVESTIGATE MY QUALIFICATIONS, AND I AUTHORIZE ALL PHYSICIANS, HOSPITALS, PHARMACIES, AND ALL OTHER HEALTH CARE PROVIDERS OR HEALTH INSURERS TO ALLOW ACCESS AND PROVIDE COPIES OF ALL OF MY PERSONAL MEDICAL RECORDS TO AUTHORIZED PERSONNEL OF THE MISSOURI DEPARTMENT OF TRANSPORTATION OR THE MISSOURI HIGHWAYS AND TRANSPORTATION COMMISSION FOR THESE PURPOSES.

I CERTIFY THAT IF ANY INFORMATION PROVIDED TO MODOT IN RELATION TO THIS APPLICATION, INCLUDING (BUT NOT LIMITED TO) MY ADDRESS, PHYSICAL CONDITION, DRIVING RECORD, LICENSE STATUS, OR ANY OTHER PERTINENT INFORMATION, SHALL CHANGE OR BECOME INCORRECT AFTER THIS DATE, THEN I WILL IMMEDIATELY FILE AMENDED OR SUPPLEMENTAL INFORMATION, SO THAT ALL RELEVANT INFORMATION PROVIDED TO MODOT IS KEPT CURRENT AND ACCURATE.

I UNDERSTAND THAT, IF A SPE CERTIFICATE IS ISSUED TO ME, THEREAFTER MODOT MAY SUSPEND AND REVOKE ANY SPE CERTIFICATE ISSUED TO ME IF I VIOLATE OR FAIL TO COMPLY WITH ANY APPLICABLE TRAFFIC LAWS, REGULATIONS OR ORDERS, OR ANY CONDITIONS STATED IN MY SPE CERTIFICATE, OR IF I AM INVOLVED IN ANY TRAFFIC ACCIDENT OR CRASH WHILE DRIVING ANY MOTOR VEHICLE.

**I FURTHER DECLARE UNDER PENALTY OF PERJURY** UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

| APPLICANT'S SIGNATURE | DATE SIGNED: |
|---|---|
| APPLICANT'S NAME (Printed) | |

## SECTION 6. EMPLOYER CERTIFICATION AND VERIFICATION

**I FURTHER DECLARE UNDER PENALTY OF PERJURY** UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

| EMPLOYER'S NAME (Printed) | EMPLOYER'S TITLE (Printed) |
|---|---|
| EMPLOYER'S SIGNATURE | DATE SIGNED: |

*NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.*