

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

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 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.

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 on the Safety & Compliance page. Be certain to include forms provided by other agencies, such as a motor vehicle driving record or a federal SPE certificate. See the next page for a list of required supporting documents.

NOTE: MoDOT is neither responsible for selecting the medical specialist(s) needed to complete the application, providing the vehicle for a skill evaluation or for any expenses incurred. These are the applicant's responsibility.

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 of 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.
- A copy of your 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.
- A 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)

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



MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

SPEC-B FORM (Statement of Treating Physician,
Required by RSMo 622.555)

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

MAIL COMPLETED FORM TO:	ATTN: MEDICAL EXEMPTION PROGRAM MOTOR CARRIER SERVICES PO BOX 270 JEFFERSON CITY, MO 65102-0270	IF ASSISTANCE NEEDED, CALL: 573-522-4937 OR Toll Free at 866-831-6277 FAX 573-522-4260
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SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT (To be completed by driver applicant).

DRIVER-APPLICANT'S FULL NAME					
RESIDENCE ADDRESS			GENDER (Please check one box) <input type="checkbox"/> MALE <input type="checkbox"/> 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		

SECTION 2. IDENTIFICATION OF TREATING PHYSICIAN

TREATING PHYSICIAN'S BUSINESS NAME			BOARD CERTIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO		
TREATING PHYSICIAN'S FULL NAME			BOARD ELIGIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO		
BUSINESS ADDRESS					
CITY	STATE	ZIP			
(AREA CODE) OFFICE TELEPHONE # ()	(AREA CODE) OFFICE FAX # ()	PROFESSIONAL CERTIFICATION #			
NAME OF CERTIFYING ORGANIZATION			PROFESSIONAL LICENSE #		
ADDRESS OF CERTIFYING ORGANIZATION					
CITY	STATE	ZIP			

SECTION 3. TO BE COMPLETED BY TREATING PHYSICIAN

<input type="checkbox"/> A	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.
<input type="checkbox"/> B	IS THE PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH ACTUAL TREATMENT? ←CHECK BOX TO CONFIRM COMPLETION.
<input type="checkbox"/> YES - HOW LONG?	<input type="checkbox"/> NO - EXPLAIN:

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



MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

SPEC-C FORM (WAIVER OF PRIVACY)

WAIVER OF PRIVACY REGARDING PERSONAL HEALTH INFORMATION

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

**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:** _____

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

(or sticker)

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)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY (continued)

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

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: _____ DOB: _____ Exam Date: _____

TESTING

Pulse rate: _____ Pulse rhythm regular: Yes No Height: ___ feet ___ inches Weight: ___ pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting			Urinalysis is required. Numerical readings must be recorded.				
Second reading (optional)							
Other testing if indicated			<i>Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.</i>				
<div style="border: 1px solid black; height: 30px;"></div>							

<p>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.</p>			<p>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).</p>			
Acuity	Uncorrected	Corrected	Horizontal Field of Vision	Check if hearing aid used for test: <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Neither		
Right Eye:	20/ _____	20/ _____	Right Eye: _____ degrees	Whisper Test Results		
Left Eye:	20/ _____	20/ _____	Left Eye: _____ degrees	Record distance (in feet) from driver at which a forced whispered voice can first be heard		
Both Eyes:	20/ _____	20/ _____		_____		
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors			Yes <input type="radio"/>	No <input type="radio"/>	OR	
Monocular vision			<input type="radio"/>	<input type="radio"/>	Audiometric Test Results	
Referred to ophthalmologist or optometrist?			<input type="radio"/>	<input type="radio"/>	Right Ear	
Received documentation from ophthalmologist or optometrist?			<input type="radio"/>	<input type="radio"/>	Left Ear	
			<input type="radio"/>	<input type="radio"/>	500 Hz 1000 Hz 2000 Hz 500 Hz 1000 Hz 2000 Hz	
			<input type="radio"/>	<input type="radio"/>	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	<input type="radio"/>	<input type="radio"/>	8. Abdomen	<input type="radio"/>	<input type="radio"/>
2. Skin	<input type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input type="radio"/>	<input type="radio"/>
3. Eyes	<input type="radio"/>	<input type="radio"/>	10. Back/Spine	<input type="radio"/>	<input type="radio"/>
4. Ears	<input type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input type="radio"/>	<input type="radio"/>	13. Gait	<input type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input type="radio"/>	<input type="radio"/>	14. Vascular system	<input type="radio"/>	<input type="radio"/>

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: _____ 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: _____ 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:

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, signature and date.
- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.
- **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, signature and date.
- **Medical Examiner's Certificate Expiration Date:** Enter the date the **driver's** Medical Examiner's Certificate (MEC) expires.

- 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>.**

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 1 minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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 Accompanied by a _____ waiver/exemption Driving within an exempt intracity zone ([49 CFR 391.62](#)) *(Federal)*
 - Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate 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

CLP/CDL Applicant/Holder

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____ Yes No

****This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.****

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-protection 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-protection 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 stationary objects	_____
Parks correct distance from curb	_____
Secures unit properly - sets parking brake, transmission 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 intersection is clear _____
 - Restricts traffic from passing on right when preparing 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

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? _____
	<small>(STREET) (CITY) (STATE & ZIP CODE)</small>	
	_____	HOW LONG? _____
	<small>(STREET) (CITY) (STATE & ZIP CODE)</small>	

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS - DRIVER

DRIVER LICENSES	STATE	LICENSE NO.	TYPE	EXPIRATION DATE

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.



MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

SPEC-2 FORM (APPLICANT WITH IMPAIRED VISION)

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

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

SECTION 1. INDIVIDUAL OR JOINT APPLICATION

<input type="checkbox"/> ←CHECK THIS BOX IF INDIVIDUAL DRIVER APPLICATION. SECTIONS 1 TO 8 OF APPLICATION MUST BE COMPLETED.	<input type="checkbox"/> ←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) <input type="checkbox"/> MALE <input type="checkbox"/> 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.
←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 <input type="checkbox"/> ←CHECK BOX IF APPLICANT IS NOW EMPLOYED BY A MOTOR CARRIER.	B <input type="checkbox"/> ←CHECK BOX IF APPLICANT IS NOW EMPLOYED, BUT NOT BY ANY MOTOR CARRIER.	C <input type="checkbox"/> ←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.
←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.
←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.
←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).
←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	
<input type="checkbox"/> 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.
<input type="checkbox"/> 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.
<input type="checkbox"/> 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-ELIGIBLE OPTHALMOLOGIST OR OPTOMETRIST . (GENERAL PRACTITIONER IS NOT ACCEPTABLE!) ←CHECK BOX TO CONFIRM THAT THE COMPLETED OPTOMETRIST/OPHTHALMOLOGIST CERTIFICATION IS ATTACHED.
<input type="checkbox"/> 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 OPTHALMOLOGIST, 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.
<input type="checkbox"/> E	←CHECK BOX TO CONFIRM THAT THE COMPLETED SPEC-F FORM , ENDOCRINOLOGIST CERTIFICATION IS ATTACHED.
F Yes <input type="checkbox"/> No <input type="checkbox"/>	DOES THE APPLICANT NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH DIABETES?
G Yes <input type="checkbox"/> No <input type="checkbox"/>	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	
<input type="checkbox"/> 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 EXEMPTIONS 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.	
<input type="checkbox"/> 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.
<input type="checkbox"/> 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.

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

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.
 ←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 # ()
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	

SECTION 4. VISUAL ACUITY

RIGHT EYE	CORRECTED:	LEFT EYE	CORRECTED:
	UNCORRECTED:		UNCORRECTED:

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

A	YES <input type="checkbox"/> NO <input type="checkbox"/>	DOES THE APPLICANT HAVE ANY EVIDENCE OF DIABETIC RETINOPATHY (I.E., DISEASE OF BLOOD VESSELS IN THE RETINA)? EXPLAIN:

B	YES <input type="checkbox"/> NO <input type="checkbox"/>	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 <input type="checkbox"/>	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 <input type="checkbox"/>	IS THE PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH ACTUAL TREATMENT? ←CHECK BOX TO CONFIRM COMPLETION.
<input type="checkbox"/> YES - HOW LONG?	<input type="checkbox"/> NO - EXPLAIN:

E <input type="checkbox"/>	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.
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SECTION 6. VISION PROFESSIONAL'S CERTIFICATION

A	YES <input type="checkbox"/> NO <input type="checkbox"/>	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.
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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:
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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:
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MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

SPEC-E FORM

(AFFIDAVIT OF DRIVING
EXPERIENCE)

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

MAIL COMPLETED FORM TO:	ATTN: MEDICAL EXEMPTION PROGRAM MOTOR CARRIER SERVICES PO BOX 270 JEFFERSON CITY, MO 65102-0270	IF ASSISTANCE NEEDED, CALL: 573-522-4937 OR Toll Free at 866-831-6277 FAX 573-522-4260
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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 YES <input type="checkbox"/> NO <input type="checkbox"/>	IS APPLICANT PRESENTLY EMPLOYED BY YOU TO OPERATE A COMMERCIAL MOTOR VEHICLE(S)?		
B YES <input type="checkbox"/> NO <input type="checkbox"/>	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 # ()

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 <input type="checkbox"/>	PLEASE DESCRIBE IN YOUR OWN WORDS, THE DRIVER'S PERFORMANCE WHILE UNDER YOUR EMPLOYMENT AS A DRIVER. PLEASE INCLUDE ANY AND ALL DETAILS YOU DEEM RELEVANT TO THE DRIVER'S QUALIFICATIONS. ← CHECK BOX IF MORE SPACE IS NEEDED AND YOU USE THE BACKSIDE OF THIS FORM.

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: