

MEDICAL EXAMINER'S CERTIFICATE

B-328 Rev. 11-2013

STATE OF CONNECTICUT - DMVOn The Web At ct.gov/dmv**I CERTIFY THAT I HAVE EXAMINED** *(Print Name of Individual Below)*

In accordance with 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:

- | | |
|--|--|
| <input type="checkbox"/> Wearing Corrective Lenses | <input type="checkbox"/> Driving within an exempt intracity zone (49 CFR 391.62) |
| <input type="checkbox"/> Wearing Hearing Aid | <input type="checkbox"/> Accompanied by a Skill Performance Evaluation Certificate (SPE) |
| <input type="checkbox"/> Qualified by operation of 49 CFR 391.64 | <input type="checkbox"/> Accompanied by a _____ waiver/exemption |

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER**TELEPHONE NO.****DATE****X****MEDICAL EXAMINER'S NAME** *(Please Print Clearly)*

- | | | |
|---|--|--|
| <input type="checkbox"/> MD | <input type="checkbox"/> DO | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Advanced Practice Nurse | |
| <input type="checkbox"/> Other Practitioner | | |

MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE**NATIONAL REGISTRY NO.****SIGNATURE OF DRIVER****INTRASTATE ONLY****CDL****DRIVER'S LICENSE NO.****STATE****X** Yes No Yes No**ADDRESS OF DRIVER****MEDICAL CERTIFICATION EXPIRATION DATE**

Please keep this card for your record do not mail to the DMV.