

Form MCSA-5973

OMB No. 2126-0006 Expiration Date: 03/31/2025

**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: Benedetto First Name: Dominic Middle Initial: G Date of Birth: 04/06/2002 Age: 21  
 Street Address: 15733 35th DR SE City Bothell State/Province: WA Zip Code: 98012  
 Driver's License Number: WDL68S7J553B Issuing State/Province: WA Phone: (206)734-5446  
 E-mail (optional): \_\_\_\_\_ CLP/CDL Applicant/Holder\*:  Yes  No  
 Driver ID Verified By\*\*: Drivers License  
 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

Empty box for listing surgery history.

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

Empty box for listing current medications.

(Attach additional sheets if necessary)

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Benedetto First Name: Dominic DOB: 04/06/2002 Exam Date: 02/12/2024

HEALTH HISTORY (continued)

Table with 3 columns: Question, Yes, No, Not Sure. Contains 32 health-related questions such as 'Head/brain injuries or illnesses', 'Seizures, epilepsy', 'Eye problems', etc.

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: [Signature] Date: 2/12/2024 4:16:51 PM

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).

[Empty box for medical examiner's review and comments]

(Attach additional sheets if necessary)

benedetto

First Name: Dominic

OMB No. 2128-0006 Expiration Date: 03/31/2025

DOB: 04/06/2002

Exam Date: 02/12/2024

rate: 78

Pulse rhythm regular:  Yes  No

Height: 5 feet 11 inches Weight 165 pounds

Blood Pressure	Systolic	Diastolic
Sitting	122	82
Second reading (optional)		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.005	Negative	Negative	Negative

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/ <u>      </u>	20/ <u>20</u>	Right Eye: <u>85</u> degree
Left Eye:	20/ <u>      </u>	20/ <u>20</u>	Left Eye: <u>85</u> degree
Both Eyes:	20/ <u>      </u>	20/ <u>15</u>	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors  Yes  No

Monocular vision  Yes  No

Referred to ophthalmologist or optometrist?  Yes  No

Received documentation from ophthalmologist or optometrist?  Yes  No

**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  Right Ear  Left Ear  Neither

**Whisper Test Results**

Record distance (in feet) from driver at which a forced whispered voice can first be heard

Right Ear	Left Ear
<u>5</u>	<u>5</u>

**Audiometric Test Results**

Right Ear:                                          

500 Hz 1000 Hz 2000 Hz

Left Ear:                                          

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**

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

normal exam

(Attach additional sheets if necessary)

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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:** Benedetto **First Name:** Dominic in accordance with (please check only

- 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)
- Grandfathered from State requirements (State)

Medical Examiner's Certificate Expiration Date

02/12/2026

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 Signature

Gibbons, Eileen

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

MD00034303

Medical Examiner's Telephone Number

(425)259-0300

Date Certificate Signed

02/12/2024

- MD
- DO
- Physician Assistant
- Chiropractor
- Advanced Practice Nurse
- Other Practitioner (specify) \_\_\_\_\_

Issuing State

WA

National Registry Number

8725296996

Driver's Signature

Driver's Address

Street Address: 15733 35th DR SE

City: Bothell

State/Province: WA

Zip Code: 98012

CLP/CDL Applicant/Holder

Yes  No

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Federal Motor Carrier  
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## Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: Benedetto First Name: Dominic 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  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

02/12/2026

Medical Examiner's Signature

*Eileen Gibbons M.D.*

Medical Examiner's Name *(please print name)*

Gibbons, Eileen

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

MD00034303

Medical Examiner's Telephone Number

(425)259-0300

Date Certificate Signed

02/12/2024

MD  Physician Assistant  Advanced Practice Nurse

DO  Chiropractor  Other Practitioner *(specify)* \_\_\_\_\_

Issuing State

WA

National Registry Number

8725296996

Driver's Signature

*Dominic Benedetto*

Driver's License Number

WDL68S7J553B

Issuing State/Province

WA

Driver's Address

Street Address: 15733 35th DR SE

City: Bothell

State/Province: WA

Zip Code: 98012

CLP/CDL Applicant/Holder

Yes  No