Date: [Date]

To: [Employer Name / Department of Transportation]

Subject: Medical Clearance for Commercial Driver Performance

Driver Name: [Driver Full Name]
Date of Birth: [DOB]
Driver's License Number: [License Number]

To Whom It May Concern,

I have performed a physical examination on the above-named individual on [Date of Examination]. This examination was conducted in accordance with the Federal Motor Carrier Safety Administration (FMCSA) physical qualification standards (49 CFR 391.41).

Based on my clinical findings and the driver's medical history, I have determined the following:

[ ] The driver is medically fit to operate a commercial motor vehicle without restrictions.
[ ] The driver is medically fit to operate a commercial motor vehicle with the following restrictions: [List Restrictions, e.g., Corrective Lenses, Hearing Aid].

This medical clearance is valid until [Expiration Date].

If you require further information regarding this medical evaluation, please contact my office at [Phone Number].

Sincerely,

[Signature of Medical Examiner]

Medical Examiner Name: [Printed Name]
Professional Designation: [e.g., MD, DO, PA, NP]
National Registry Number: [Registry Number]
Clinic Name: [Clinic/Facility Name]
Address: [Clinic Address]