

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 one 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-PRA, 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: SALMON First Name: ROY 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

5/5/2025

Medical Examiner's Signature



Medical Examiner's Telephone Number

410-902-6776

Date Certificate Signed

5/5/2023

Medical Examiner's Name (please print or type)

Jason Olszewski

☐ MD ☒ Physician Assistant ☐ Advanced Practice Nurse☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____

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

C03608

Issuing State

MD

National Registry Number

3622119266

Driver's Signature



Driver's License Number

S455744067351

Issuing State/Province

MD

Driver's Address

Street Address: 9737 EUSTICE RD

City: RANDALLSTOWN

State/Province: MD

Zip Code: 21133

CLP/CDL Applicant/Holder

☒ 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.

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-RRR, 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)

4640/4640-0

(or sticker)

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

Last Name: SALMON First Name: ROY Middle Initial: Date of Birth: 5/8/1975 Age: 47

Street Address: 9737 EUSTICE RD City: RANDALLSTOWN State/Province: MD Zip Code: 21133

Driver's License Number: S455744067351 Issuing State/Province: MD Phone: 443-629-4648

E-Mail (optional): CLP/CDL Applicant/Holder*: ☒ Yes ☐ No

Driver ID Verified By**: DRIVER'S 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

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: SALMON

First Name: ROY

DOB: 5/8/1975

Exam Date: 5/5/2023

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 checked="" type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
2. Seizures/epilepsy	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems Insulin used	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input checked="" 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: 5/5/2023**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: SALMON First Name: ROY DOB: 5/8/1975 Exam Date: 5/5/2023

TESTING

Pulse Rate: 80 Pulse rhythm regular: ☒ Yes ☐ No Height: 5 feet 10 inches Weight: 200 pounds

Blood Pressure	Systolic	Diastolic
Sitting	164	90
Second reading (optional)	138	88

Other testing if indicated

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.020	NEGATIVE	NEGATIVE	NEG (NORMAL)

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:	20/30	20/	Right Eye: 85 degrees
Left Eye:	20/30	20/	Left Eye: 85 degrees
Both Eyes:	20/30	20/	

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 test: ☐ Right Ear ☐ Left Ear ☒ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance (in feet) from driver at which a forced whispered voice can first be heard	5	5

OR

Audiometric Test Results

Right Ear:	Left Ear:
500 Hz 1000 Hz 2000 Hz	500 Hz 1000 Hz 2000 Hz
Average (right):	Average (left):

PHYSICAL EXAMINATION

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

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	<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.

BMI: 28.69

(Attach additional sheets if necessary)

Last Name: SALMON First Name: ROY DOB: 5/8/1975 Exam Date: 5/5/2023

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

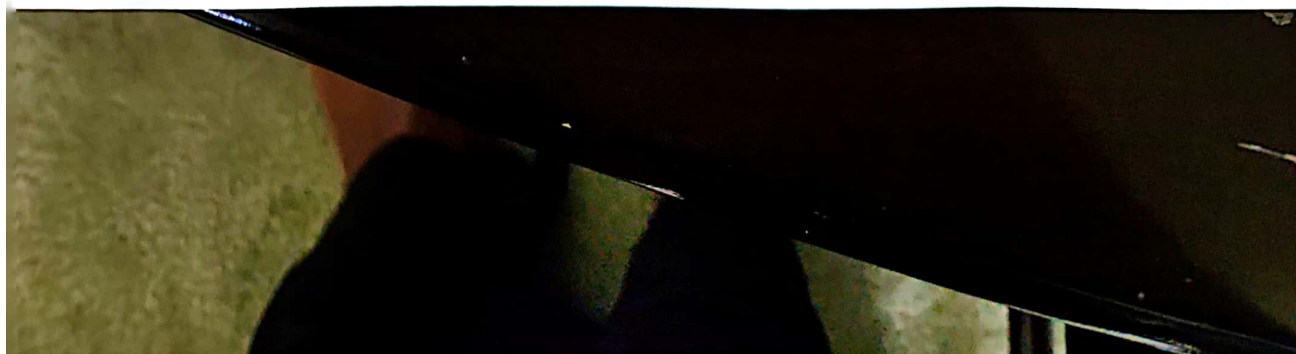
MEDICAL EXAMINER DETERMINATION (Federal)Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations ([49 CFR 391.41-391.49](#)):

- ☐ 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): Jason OlszewskiMedical Examiner's Address: 10210 REISTERSTOWN RD City: OWINGS MILLS State: MD Zip Code: 21117Medical Examiner's Telephone Number: 410-902-6776 Date Certificate Signed: 5/5/2023Medical Examiner's State License, Certificate, or Registration Number: C03608 Issuing State: MD☐ MD ☐ DO ☒ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse☐ Other Practitioner (specify): _____National Registry Number: 3622119266Medical Examiner's Certificate Expiration Date: 5/5/2025

Last Name: SALMON First Name: ROY DOB: 5/8/1975 Exam Date: 5/5/2023

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: _____